DEPT.-65

JOB- 21

REEL- 26

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF VITAL STATISTICS

DEATHS

BEGINNING 1910

KP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8201

HEALTH DEPARTMENT—CITY OF BALTIMORE

50

D 8201

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 Josephine ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 642 Josephine ave St.; 57 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6-DATE OF BIRTH, ... August (Month) ..... 1 (Day) ..... (Year)

7-AGE, ... 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Pri Family

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Hilard

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Laura Smith

(Address) 642 Josephine St

15- ROBERT B. KRAUTER

Filed SEP 6 - 1917 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... September (Month) ..... 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20th 1916, to September 3d 1917, that I saw her alive on September 3 1917, and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....Diabetes.....

..... (Duration) 1 yrs. 7 mos. 16 ds.

CONTRIBUTORY (Secondary) Paralysis

..... (Duration) ..... yrs. ..... mos. 1 day

(Signed) Frank M Gruner M. D.

Sept 6, 1917. (Address) 322 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 6, 1917

20-UNDERTAKER, Wm H. Ford — ADDRESS 578 W Balto

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 W Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Garrett

(Residence in Baltimore: No. 832 Lexington St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) 1868 (Day) 1 (Year)

7-AGE, 49 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Trained Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Garrett

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sophia

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Garrett

(Address) 832 Lexington St.

15- Filed SEP 5 - 1917, 191... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 3d, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1917, to Sept. 3d 1917, that I saw h— alive on August 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart 6 hrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pelvic Cellulitis 6
(Duration) yrs. mos. ds.

(Signed) A. Lee Hall M. D.

Sept 5, 1917, (Address) 824 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. | DATE OF BURIAL, Sept. 6., 1917.

20-UNDERTAKER Edwards B. Jones | ADDRESS 235 N. Pine

Spec.—5-19-13—M. & T.—500 Bks.

D 8203 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Vincent ST.; 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl W. Huss Jr.

(Residence in Baltimore: No. 206 S. Vincent St.; X yrs., 8 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, 12 (Month) — 31 (Day), 1916 (Year)

7-AGE,	If LESS than 1 day,
0 yrs. 8 mos. 4 ds.	X hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. City Md.

PARENTS.

10-NAME OF FATHER, Carl W. Huss

11-BIRTHPLACE OF FATHER (State or Country), Balto. City. Md

12-MAIDEN NAME OF MOTHER Annie Daughert

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C W. Huss

(Address) 206 S Vincent St

15-

Filed SEP 6 - 1917, 191

ROBERT B. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 4 1917, that I saw him alive on Sept 3 1917, and that death occurred, on the date stated above, at 9.40 a m.

The CAUSE OF DEATH* was as follows:

Mal nutrition and Enteritis

(Duration) X yrs. 1 mos. X ds.

CONTRIBUTORY (Secondary) Spasms + Exhaustion

(Duration) X yrs. X mos. 1 ds.

(Signed) P. B. Wilson M. D.

9-4, 1917. (Address) 1939 Wilkens Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Sept 6th, 1917.
20-UNDERTAKER	ADDRESS
John J. Fields	1200 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8204

104 8204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp'l ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Butler

(Residence in Baltimore: No. 423 Hamburg St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) child

6-DATE OF BIRTH, July 23, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elmer Butler

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Viola Boggs.

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Sibley

(Address) Johns Hopkins Hosp.

15-

Filed SEP 6 1917 191....

ROBERT B. KRAUTER
Registrar.

Burial Permit ISSD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1st, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 30 1917, to Sep 1 1917, that I saw him alive on Sep 1 1917, and that death occurred, on the date stated above, at 330 m.

The CAUSE OF DEATH* was as follows:

gastro-intestinal indigestion

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY —
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Margaret Tyler M. D.

Sept 1, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 423 Hamburg St

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8205 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8205

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Laurens St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Smith

(Residence in Baltimore: No. 1804 Laurens St St.; ..... yrs., ... mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug. 24, 1917.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. 11 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Christina Hendy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Smith

(Address) 1804 Laurens St.

15-

Filed SEP 6 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 1917, to Sept 5 1917, that I saw him alive on Sept 5 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Sylvester M. D.

Sept. 6, 1917. (Address) 1507 E. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Sept 7, 191.7

20-UNDERTAKER Howard & Dorsey ADDRESS 1644 Mc Cu

Spec.—8-24-14—M. & T.—2000 Bks.

D 8206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8206

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3026 St. Paul ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen F. Norris

(Residence in Baltimore: No. 3026 St Paul St.: 52 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 13, 1853 (Month) (Day) (Year)

7-AGE, 64 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Balto City Coll

9-BIRTHPLACE, (State or Country). St. Marys Co. Md

PARENTS.

10-NAME OF FATHER. J. Washington Norris

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Hannah R. Fowler

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caswell C. Norris

(Address) 3026 St. Paul St.

15-

Filed SEP 6 1917, 191.... ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Sept 4 1917, that I saw him alive on Sept 4 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

6 hours Arterial Hypertension

General Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage about 6 hours

(Duration) yrs. mos. ds.

(Signed) G. Carroll Lockard M. D.

Sept 4, 1917. (Address) 4 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Sept 6, 1917

20-UNDERTAKER John C. Mitchell ADDRESS 1200 W. Fayette

D. 8207.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D. 8207.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth S. Priester

(Residence in Baltimore: No. 511 North Stricker St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 3 (Day), 1877 (Year)

7-AGE, 39 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirt Operator
(b) General nature of industry, business, or establishment in which employed (or employer):

35-7

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Priester

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Hannah V Hecker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Augusta Smith

(Address) 640 N Carey

15-

Filed SEP 6 1917, 191.. ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

CAUSE OF DEATH is particularly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 1 (Day), 5 (Year), 1917

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Head

Shear accident

(Duration) yrs. mos. ds.

CONTRIBUTORY: (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 5, 1917 (Address) W. & Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Westerne Cemetery — DATE OF BURIAL, Sept 7, 1917

20-UNDERTAKER William Cook — ADDRESS 504 E. North Ave

D 8208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8208

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilmer Hall

(Residence in Baltimore: No. Poplar Calvert Co. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, October, 1 (Month) (Day) (Year)

7-AGE 25 yrs. mos. ds.

If LESS than 1 day. hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Calvert Co.

PARENTS.

10-NAME OF FATHER, Thomas E Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ella Grissom

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father & Wife

(Address) Prince Fred Co Md

15- Filed SEP 6 1917 191 ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation & Exhaustion

Pneumonia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A J Riley M. D. (Coroner.)

Sept 6 1917 (Address) 1059 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Prince Fredk Co Md

Former or usual residence Poplar Calvert Co

19-PLACE OF BURIAL OR REMOVAL, Prince Fredrick DATE OF BURIAL, Sept 6 1917

20-UNDERTAKER Chas Gray & Son ADDRESS 715 Eutaw

CAUSE OF DEATH. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8209

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 N Bradford ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances F. Watkins

(Residence in Baltimore: No. 1224 N Bradford St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb (Month) 10 (Day), 1917 (Year)

7-AGE, — yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo H. Watkins

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Anna Walz

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H Watkins

(Address) 1224 N Bradford St

15- SEP 6- 1917 HARRY C. ANDREWS

Filed....., 191.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Sept 5 1917, that I saw h— alive on Sept 4 1917, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

(a) Cystic Carcinoma

(Duration) 1 yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Ex Examination

(Duration) 1 yrs. 0 mos. 1 ds.

(Signed) Walter Randolph M. D.

Sept 5, 1917. (Address) 1102 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 6th, 1917

20-UNDERTAKER Geo M. Frick — ADDRESS 811 N Wolfe

Important: Be sure to answer all questions.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8210

CERTIFICATE OF DEATH.

104 D 8210

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Monte Carlo

(Residence in Baltimore: No. 1012 Hesterling Court St.; — yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, September 5, 1916.
(Month) (Day) (Year)

7-AGE, 0 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, John Carlo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Caroline Desard

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry L. Klumpher

(Address) John Hopkins Hosp

15- SEP 6 1917 HENRY C. ANDREWS

Filed ....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 1917, to Sept 5 1917, that I saw h[illegible] alive on September 6 1917, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion Acute

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Conrad M. D.

Sept 5, 1917. (Address) John Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1012 Hesterling Court

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery — DATE OF BURIAL, Sept 7, 1917.

20-UNDERTAKER Einstein Miller — ADDRESS [illegible]

Important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8211

D 8211

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Barrington Rd ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Selden Ely.

(Residence in Baltimore: No. 3816 Barrington Rd ; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH, aug (Month) 16 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Non
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Selden R Ely

11-BIRTHPLACE OF FATHER (State or Country), Newyork ny

12-MAIDEN NAME OF MOTHER Jennie Buffington

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Selden R. Ely

(Address) 3816 Barrington Rd

15-

Filed....., 191.....

HARRY [illegible]
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/1 1917, to 9/6 1917, that I saw him alive on 9/5 1917, and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as followa:

Malnutrition

..... (Duration) ....yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Premature birth (8 mo)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

9/6/, 1917. (Address) 2020 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodland Ridge

DATE OF BURIAL, Sept 8, 1917.

20-UNDERTAKER Horace Bangert

ADDRESS 3616 Falls Rd

Imperative

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8212 — 138 — D 8212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital — REGISTERED NO. C

CITY OF BALTIMORE: (No. ... ST.; 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Margaret Shriner

(Residence in Baltimore: No. 604 Wyanoke Ave St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Oct. 25 (Month) (Day), 1895 (Year)

7-AGE, 21 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Davis Shirley

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Daisy Bozgat

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. D. Shirley

(Address) 604 Wyanoke Ave

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, bilateral

Lasting six hours

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Contributory cause unknown

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) John M. C. Bayland M. D.

Sept. 6..., 1917. (Address) 4 W. Read Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ditto

Former or usual residence 604 Wyanoke Ave

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Sept 9, 1917.

20-UNDERTAKER Wm J. Dickmeyer Son — ADDRESS North Ave

D 8213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8213
REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hilton st near Frederick ST. 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allison K. Bird

(Residence in Baltimore: No. 1425 W Lanvale St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	husband

6-DATE OF BIRTH, May (Month) 26 (Day), 1852 (Year)

7-AGE, 65 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or.....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Builder

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.
10-NAME OF FATHER, William Bird
11-BIRTHPLACE OF FATHER (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Caroline Knighton
13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. E. Bird
(Address) Brookville N.Y.

15-
Filed....., 191.....
HARRY C. ANDREWS
Burial Permit Issued
Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) acute Dilatation of heart (Duration) sudden yrs. mos. ds.
(Signed) James McFeeley M. D.
(Coroner.)
Sept 6, 1917 (Address) 707 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pardoorell Md	Sept 7, 1917
20-UNDERTAKER	ADDRESS
W. H. Eichner Sons	North Pk.

D 8214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

XP D 8214

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Burrs

(Residence in Baltimore: No. Towson Md. St., — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Sallie Burrs

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Lawson

(Address) Towson

15-

Filed SEP 6 1917, 191 ROBT. O. JANNEY Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following injuries Caused by being Struck by Automobile driven by Unknown person (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) A. S. Donovan M. D. (Coroner)

Sept 6 1917 (Address) 312 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS): At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Towson Md

Former or usual residence Towson Md

19-PLACE OF BURIAL OR REMOVAL: Pleasant Rest Cem. DATE OF BURIAL: Sept 6 1917

UNDERTAKER: John Burns Sons ADDRESS: Towson Towson Md

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8215

CERTIFICATE OF DEATH.

D 8215

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Fremont Ave. St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Steinmann

(Residence in Baltimore: No. 2027 W. Saratoga St.)

St. Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, March (Month) 16 (Day), 1895 (Year)

7-AGE, 22 yrs. 5 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Gerhard.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Briesenhafer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gerhard Steinmann

(Address) 2027 W. Saratoga St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 5 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1917, to Sept 5 1917, that I saw him alive on Sept 5 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 33 ds.

CONTRIBUTORY (Secondary) Hemorrhage of Intestines

(Duration) yrs. mos. ds.

(Signed) Myles B. Sharkey M. D.

Sept 5, 1917. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 23 ds. In the State ... yrs. Life mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2027 W. Saratoga St.

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. 9 8, 1917

20-UNDERTAKER H. C. Rammensee

ADDRESS 511 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8216

CERTIFICATE OF DEATH.

91 D 8216

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Rosenthal

(Residence in Baltimore: No. 135 S. Central Ave. St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	child

6-DATE OF BIRTH, May (Month) 5 (Day) 1911 (Year)

7-AGE, 6 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Vineland N. J.

PARENTS.

10-NAME OF FATHER, Jacob M. Rosenthal

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kate Audit

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin

(Address) 1411 E Balto St

15-

Filed....., 191.....

HARRY C. ARCHER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1917, to Sept. 6 1917, that I saw h[illegible] alive on Sept. 6 1917, and that death occurred, on the date stated above, at 2.35 p.m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

..... (Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

2. Pertussis (Duration) ... yrs. ... mos. 9 ds.

(Signed) Bernard Jacobson M. D.

Sept 6, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 9 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? 135 S. Central Ave

Former or usual residence 135 S Central Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Mt Carmel	9/7, 1917

20-UNDERTAKER	ADDRESS
Jack Levin	1411 E Balto

important. See instructions on ...

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8217

CERTIFICATE OF DEATH.

151

D 8217

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 St Peter ST.; 21 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Gray Leadley

(Residence in Baltimore: No. (Life) 729 St Peter St.; X yrs., X mos. X ds.) 3 hours

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 6th (Month) (Day), 1917 (Year)

7-AGE, X yrs. X mos. X ds.

If LESS than 1 day, 5 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... X
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter C. Leadley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Horel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter C. Leadley

(Address) 729 St Peter St

15-

Filed ..., 191... Registrar.

SEP 6 1917 BOARD OF ANDREWS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from sept 6th 1917, to sept 6th 1917, that I saw her alive on sept 6th 1917, and that death occurred, on the date stated above, at 1.6 m.

The CAUSE OF DEATH* was as follows:

(Seven months) Interrupted pregnancy of Uterus (Unavoidable) Premature Birth— Lived 3 hours

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

4 hours (Duration) ... yrs. ... mos. ... ds.

(Signed) John L. Mauger M. D.

Sept 6th, 1917. (Address) 1002 Edmonson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn cemetery — DATE OF BURIAL, Sept 7, 1917

20-UNDERTAKER Harry A. Vitzke — ADDRESS 1531 W. Lanvale St

important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8218

CERTIFICATE OF DEATH.

104

D 8218

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2611 N Bailo. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Josephine Jessup.

(Residence in Baltimore: No. 2611 N Bailo St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 21, 1917
(Month) (Day) (Year)

7-AGE, yrs. 2 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Elmer E Jessup

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Grace M Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer E Jessup

(Address) 2611 W. Balto Md

15-

Filed SEP 7 1917, 191 ROBERT P. KRAUTER Registrar.

Burial Permit Given

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1917, to Sept 6 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Infantile Atrophy ?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(Duration) yrs. mos. 7 ds.

(Signed) Dr Thos M Rucker M. D.

Sept 7, 1917. (Address) 345 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Sept 8, 1917.

20-UNDERTAKER Wm Cook

ADDRESS 912 E North ave

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8219

CERTIFICATE OF DEATH.

D. 8219

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 W Lexington ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Jane Hewitt

(Residence in Baltimore: No. 1520 W Lexington St St.; 40 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 19 (Day), 1842 (Year)

7-AGE, 75 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Estella M. Keauter

(Address) 1820 W Lexington St

15-

Filed SEP 7 1917, 191 ROBERT R. KEAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1917, to Sept 4 1917, that I saw h[illegible] alive on Sept 4 1917, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Mary E. Merritt M. D.

Sept 5, 1917. (Address) 1502 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Sept 7, 1917

20-UNDERTAKER Joseph B. Cook ADDRESS 603 W Balt St

CAUSE OF DEATH important. See instructions on back of certificate.

D 8220 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8220

CERTIFICATE OF DEATH.

REGISTERED No. C 175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 154 n Lemmon St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. Setzer

(Residence in Baltimore: No. 154 n Lemmon St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1 (Year)

7-AGE, 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Brewing

62 M

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Setzer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Speller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Setzer

(Address) 154 n Lemmon

15- ROBERT B. KRAUTH SEP 7 1917 Burial Permit Clerk

Filed....., 191.. H.W. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Duration 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. ds.

(Signed) G. Bascom Gant M. D.
(Coroner.)

Sept 6, 19 17 (Address) 20 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Sept. 9 1917

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Sped.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8221

CERTIFICATE OF DEATH.

D 8221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Garrison ave ST.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margaret Shinn

(Residence in Baltimore: No. 2216 Garrison ave St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec. (Month) 4th (Day) 1843 (Year)

7-AGE, 74 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Levy McWhorter

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Eliza Atkins

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. G. Davis

(Address) 2216 Garrison ave

15-

Filed....., 191.....

Registrar.

SEP 7 - 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 7th 1917, to Sept. 7 1917, that I saw her alive on Sept. 6 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Ross M. D.

Sept. 7, 191 7. (Address) 1042 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Clarksburg W. Va

DATE OF BURIAL, Sept. 7., 1917.

20-UNDERTAKER Graham & Walker

ADDRESS 723 W Lo[illegible] ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 8222

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Bay ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Ray

(Residence in Baltimore: No. 721 Bay St.; 8 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sep (Month) 2d (Day), 1867 (Year)

7-AGE, 50 yrs. mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Factory Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Cotton Mill

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frank Ray

(Address) 721 Bay St.

15-

Filed....., 191.....

Registrar.

SEP 7 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1917, to Sep 6 1917, that I saw him alive on Sep. 6 1917, and that death occurred, on the date stated above, at 1st p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

(Signed) Benj. J. Cadry M. D.

Sep. 6, 1917. (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Chapel

DATE OF BURIAL, Sept. 7, 1917

20-UNDERTAKER Lorin Burgerson

ADDRESS 3411 Falls Rd

Important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

D 8223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8223

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 S. Kenwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ferdinand Bronzert

(Residence in Baltimore: No. 831 S. Kenwood Ave St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 29, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alexy Bronzert

11-BIRTHPLACE OF FATHER (State or Country), Rusia

12-MAIDEN NAME OF MOTHER Stanislawa Knach

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexy Bronzert

(Address) 831 S. Kenwood Ave

15-

Filed....., 191.....
Registrar.

Important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1st, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3 1917, to Sept 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebro Colitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Wm J Ryan M. D.

Sept 7, 1917. (Address) 2016 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Sept. 7..., 1917.
20-UNDERTAKER	**ADDRESS**
Stephen J Fialkowski	1019 S Kenwood Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8224

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 S. Harris Alley ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludwik Moskal

(Residence in Baltimore: No. 914 S. Harris Alley St.; life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 15, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 20 da. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Moskal

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Magdalena Slawik

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Moskal

(Address) 914 S. Harris Alley

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1917, to Sept 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Acute Hart Failure

a of

(Duration) ...yrs. ...mos. 1d. ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

Sept 7, 191... (Address) 1116 S Newkirk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Sept 7, 1917
20-UNDERTAKER	ADDRESS
Stephen J Stackowski	1019 Kenwood ave

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8225

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 S Gilmor ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E. Dillon

(Residence in Baltimore: No. 427 S. Gilmor St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, December (Month) ..... (Day), 1849 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Christopher P. Maguire

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Susanna Dailey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David C. Dillon

(Address) 427 S. Gilmor St.

15-

Filed ....., 191.....

Registrar.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 6 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2 1917, to Sept. 6 1917, that I saw her alive on Sept. 5 1917, and that death occurred, on the date stated above, at 2.15a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) M. A. O'Neill M. D.

Sept. 6, 1917. (Address) 108 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Sept. 8..., 1917.

20-UNDERTAKER Martin Fahey Jr. Sons ADDRESS 625 Fayette Ave

SEP 7- 1917 ROBERT B. KRAUSE

D 8226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8226

CERTIFICATE OF DEATH.

169

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Bush St. St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Faunce.

(Residence in Baltimore: No. 925 Burgundy St.

St.: yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, March 20th 1860..., 1.....
(Month) (Day) (Year)

7-AGE, 57 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in
(b) General nature of industry, business, or establishment in which employed (or employer): glass house.

251

9-BIRTHPLACE, (State or Country), Hartford Conn.

PARENTS.

10-NAME OF FATHER, William Faunce.

11-BIRTHPLACE OF FATHER (State or Country) Do not know.

12-MAIDEN NAME OF MOTHER Sarah A. Henderson.

13-BIRTHPLACE OF MOTHER (State or Country), Cedarville N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Furman C. Faunce. (son)

(Address) 925 Burgundy St.

15-

Filed ....., 191.....

Registrar.

Cause of death must be stated. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3, 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Reinhardt M. D.
(Coroner.)

Sept. 7, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mont Ewen	Sept. 7th
UNDERTAKER	ADDRESS
H. Dickmann & Son	

D. 8227.

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 8227

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Simms

(Residence in Baltimore: No. 824 Warren St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown, ... (Day) 1 ..... (Year)

7-AGE, 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework.....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 3 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) Autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
First shot wounds in right lung & Spinal Cord.
Said pistol held in hands of her husband
James Simms (Homicide)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. D. Driscoll M. D.
(Coroner.)

Sept 5, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct — DATE OF BURIAL, Sept 7 1917

20-UNDERTAKER A. D. Brown & Son — ADDRESS 108 N. Monty Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8228

D. 8228

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hazel Baggett

(Residence in Baltimore: No. 1027 Busch St. St. L yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... July (Month) ..... 25 (Day), 1884 (Year)

7-AGE, ... 23 yrs. ..... 1 mos. ..... 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Columbus Burns

11-BIRTHPLACE OF FATHER (State or Country), Washington D. C.

12-MAIDEN NAME OF MOTHER Mary E. Clark

13-BIRTHPLACE OF MOTHER (State or Country), Erie Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Mary E. Burns.....

(Address). 1027 Busch St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) ..... 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 noon 191..., to Sept 6 10 a.m. 191..., that I saw her alive on Sept 6 191..., and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Gen. Peritonitis

..... (Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppurative Appendicitis

..... (Duration) Unknown yrs. mos. ds.

(Signed) Wm. L. Steinbrough M. D.

Sept. 6, 1917. (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. 10 hrs mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 1027 Busch St

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 7, 1917.

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

D. 8229

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

50 D. 8229

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2561 W. Lombard ST. 70 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lewis Jester

(Residence in Baltimore: No. 2561. W. Lombard St.: 62 yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: March 22, 1855 (Month) (Day) (Year)

7-AGE: 62 yrs. 5 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE (State or country): Kent County Md

PARENTS

10-NAME OF FATHER: Chas. Jester

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Susan Nelson

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lucinda Jester

(Address) 2561 W Lombard St

15-

Filed ..... 191 .....

REGISTRAR

ROBERT B. HEADEN
Burial Permit Clerk

SEP 7 1917

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 4, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 191 7, to Sept 4 191 7
that I saw him alive on Sept 4, 191 7.
and that death occurred, on the date stated above, at 4 30 P m.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward J. Condon M. D.

Sept 5, 1917. (Address) 250 W. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 7, 1917

20-UNDERTAKER: Geo. A. Gerber — ADDRESS: Bond & Payson Sts

state CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

D 8230

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 ✓ D 8230

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No 527 Somerset St.: 5 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Banks

(Residence in Baltimore: No. 527 Somerset St.: ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feby 18 1916 (Month) (Day) (Year)

7-AGE: 1 yrs. 6 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): City

PARENTS

10-NAME OF FATHER: Robt Banks

11-BIRTHPLACE OF FATHER (State or country): City

12-MAIDEN NAME OF MOTHER: Chalmetta Green

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Banks

(Address) 527 Somerset

15

Filed ....., 191 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 6 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1917, to Sept 6th 1917, that I saw h- alive on Sept 6, 1917, and that death occurred, on the date stated above, at 2.30 P m.
The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ... yrs. 5 mos. ... ds

Contributory (SECONDARY) Probably Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jno N Magruder M. D.

9. 6, 1917 (Address) 15 W. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet | DATE OF BURIAL: ....., 191...

20-UNDERTAKER: Harman Funeral Home | ADDRESS

State CAUSE OF DEATH in plain terms. Statement is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8231

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D. 8231

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 N. Dolphin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernadine L Colbert

(Residence in Baltimore: No. 637 N. Dolphin St.; 29 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Widow

6-DATE OF BIRTH, May (Month) 10th (Day), 1886 (Year)

7-AGE, 31 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Porter in Garage

9-BIRTHPLACE, (State or Country). Charles Co. Md

PARENTS.

10-NAME OF FATHER, Richard A. Colbert

11-BIRTHPLACE OF FATHER (State or Country). Charles Co Md

12-MAIDEN NAME OF MOTHER Cecelia Council

13-BIRTHPLACE OF MOTHER (State or Country). Charles Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene Dixon

(Address) 607 W Dolphin St

15-

Filed....., 191.....

Burial Permit Issued SEP 7 1917 ROBERT B. ERAUTER Registrar.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 15th 1917, to Sept 4th 1917, that I saw h.... alive on Sept 4th 1917, and that death occurred, on the date stated above. at 9.40 p.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Pulmonary Tuberculosis (Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Malaria (Duration) yrs. 1 mos. — ds.

(Signed) Edward C. Mackenzie M. D.

Sept 5, 1917. (Address) 133 N. Smallwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Sept 8, 1917
20-UNDERTAKER	ADDRESS
Barnes Enright	Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D. 8232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8232

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Gombard ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Jaumann

(Residence in Baltimore: No. 604 N. Gombard St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. April 22, 1916
(Month) (Day) (Year)

7-AGE. 1 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER. Charles Jaumann

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Petrone Zygmont

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Jaumann

(Address) 604 N. Gombard

15-

Filed....., 191.....

SEP 7- 1917 ROBERT R. KRAUSE
Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1917, to Sept 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs.

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

Rheumatism (Duration) ....yrs. ....mos. ....ds. in home

(Signed) Walter A Ott M. D.

9-7, 1917. (Address) 543 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Sept 8, 1917.

20-UNDERTAKER John Gobliauckas

ADDRESS 425 So. Paca St

D 8233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

K175 D 8233

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St. 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude West

(Residence in Baltimore: No. Pumpj Station Balt Co Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James West

(Address) Pumpj Station Balt Co Md

15-

Filed SEP 7 1917 ROBERT B. KRAUTH Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull caused by Struck by Electric Car. accidental.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Donovan (Coroner) M. D.

(Sept 7, 191.) (Address) 822 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Pumpjstation Balto Co

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept 7, 1917.

20-UNDERTAKER Bart Hooper

ADDRESS 609 Lombard East

important. See instructions on back of certificate.

D 8234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8234

CERTIFICATE OF DEATH.

170

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5-16 N. Vincent ST.; 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Peters.

(Residence in Baltimore: No. 5-16 N Vincent St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colo

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ..., 1857
(Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER: Robert Peters

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Auburn

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) M Peters

(Address) 5-16 N Vincent

15-

Filed SEP 7- 1917, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Septr 5th, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Colds 2 or 3 days

(Duration) yrs. mos. ds.

(Signed) J Randolph M. D.
(Coroner)

Sept 6, 1917. (Address) 917 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER Daniel Corbett — ADDRESS 916 Pennsylvania Ave

important. See instructions on back of certificate.

D 8235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

26 D 8235

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Boyle

(Residence in Baltimore: No. 1004 N. Front Ave) 1344 N. Gay St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	?

6-DATE OF BIRTH, April 1 (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), (0)

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (May) (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest) (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest) (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Alcoholism, Probably)
Softening brain

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 ago yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, SEP 7 1917, 19....

20-UNDERTAKER ROBERT R. KRAUTH

ADDRESS

Commissioner Health.

important. See instructions on back of certificate.

D 8236 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D. 8236

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1608 N Bruce St. 15 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Bucsell

(Residence in Baltimore: No. 1608 N Bruce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOW OR DIVORCED, (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, June (Month) 30 (Day), 1907 (Year)

7-AGE, ... yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas Bulsell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Laura Nelson

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1608 N Bruce

15-

SEP 7 - 1917

Burial Permit Clerk

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary—Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H McCahan M. D.
(Coroner.)

Sept 7, 1917. (Address) 849 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? None

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, Sept. 7, 1917

20-UNDERTAKER Edward Ramsey

ADDRESS 1467 Carey

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8237

CERTIFICATE OF DEATH.

104 D 8237

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Prestman ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Addison Douglas

(Residence in Baltimore: No. 1518 Prestman St.; ....yrs.,....mos.,....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Chld.

6-DATE OF BIRTH, July (Month) 27th (Day), 1917 (Year).

7-AGE, ...yrs. 1 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, md

PARENTS.

10-NAME OF FATHER, Edward Douglas

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Elaine Addison

13-BIRTHPLACE OF MOTHER (State or Country), Wash D. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elaine Douglas

(Address) 1518 Prestman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6th (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st 1917, to Sept 6th 1917, that I saw her alive on Sept 6th 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

.....

Diarrhoea & Enteritis

..... (Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Harry T. Bruen M. D.

Sept 7th, 1917. (Address) 1501 Prestman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters County — DATE OF BURIAL, SEP 7 - 1917, 191...

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

SEP 7 1917 ROBERT E. KRAUTH HEALTH OFFICER

Spec.—8-24-14—M. & T.—2000 Bks.

8238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8238.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 W Saratoga St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Norman Boston

(Residence in Baltimore: No. 1604 W Saratoga St.; ...yrs.,...mos.,...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, May 23, 1917 (Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Boston

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Cora Owens

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Owings Boston

(Address) 1604 W. Saratoga St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-2 191 7, to 9-5 191 7, that I saw h[illegible] alive on 9-5 191 7, and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

.....

..... (Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Edward A McAlpin M. D.

9-5, 191 7 (Address) 1502 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Sept. 7, 1917.
20-UNDERTAKER	ADDRESS
James H. Dennis	1303 Pennsylvania Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8239

CERTIFICATE OF DEATH.

104 D 8239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 S. Bond St.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaw Olekzik

(Residence in Baltimore: No. 845 S. Bond St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 3 (Day) 1916 (Year)

7-AGE, 9 yrs. 27 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. John Olekzik

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland

12-MAIDEN NAME OF MOTHER Polonia Ramszewska

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Olekzik

(Address) 845 S. Bond St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 10th 1917, to September 6th 1917, that I saw h m alive on 11 6th 1917, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(Duration) yrs. 1 mos. 20 ds.

(Signed) Amelia E. Funk M. D.

Sept. 6, 1917. (Address) 1711 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	1917
20-UNDERTAKER	ADDRESS
Jacob Falkowski	428 S. Bond St.

Important. See instructions on back.

SEP 7 1917 ROBERT R. KRAUTER

Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

D 8240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 8240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes O'Riley

(Residence in Baltimore: No. 810 Greenmount Ave. St.; —yrs.,—mos.,—ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. 24, 18.66
(Month) (Day) (Year)

7-AGE, 50 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael O'Riley

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Coleman

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rec'd Mercy Hosp.

(Address) Calvert St.

15-

Filed SEP 8- 1917, 191.... HARRY C. BLUM Vital Statistics Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 191 7, to Sept 5 191 7, that I saw her alive on Sept 5 191 7 and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) Da. Not Rem.

CONTRIBUTORY (Secondary) .....

(Duration) 9 yrs. mos. ds.

(Signed) Edward L. Smith M. D.

Sept 5, 191 7 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. Jan. mos. ds. In the State ....yrs. Life mos. ds.

Where was disease contracted, if not at place of death? 810 Greenmount Ave

Former or usual residence 810 Greenmount Ave

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Sept 8, 191 7

20-UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Greenmount Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8241

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

104 D 8241

CITY OF BALTIMORE: (No. 1635 Thames. ST.; 7 WARD)

REGISTERED NO. C

2-FULL NAME Frank Jachen.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1635 Thames St.; yrs. 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 12" (Day), 1916 (Year)

7-AGE, yrs. 4 mos. 25 ds. | If LESS than 1 day, hrs. or mtu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimor Md.

PARENTS.

10-NAME OF FATHER, Stanislaus Jachen.

11-BIRTHPLACE OF FATHER (State or Country), Austria Poland

12-MAIDEN NAME OF MOTHER Carolina Mikrowna

13-BIRTHPLACE OF MOTHER (State or Country), Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaus Jachen

(Address) 1635 Thames St.

15-

Filed SEP 8 1917, 191

HARRY C. ANDERS
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6" (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Sept 6 1917, that I saw h— alive on Sept 6 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

acute Intest.

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Krawiec M. D.

Sept 8, 1917 (Address) 1635 Thames

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus | DATE OF BURIAL, Sept 8", 1917

20-UNDERTAKER W. F. Sadowski | ADDRESS 705 S. Ann St

Spec.—8-24-14—M. & T.—2000 Blks.

D 8242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8242

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Racet St. ST.; 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Watts.

(Residence in Baltimore: No. 1021 Racet St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	X

6-DATE OF BIRTH, Feb. (Month) 7 (Day), 1917 (Year)

7-AGE, ...yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 1021 Racet St.

PARENTS.

10-NAME OF FATHER, Harry Moore

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER, Sadie Watts.

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Watts

(Address) 1021 Race

15-

Filed....., 191.....

HARRY C. ANDREWS
DEPUTY REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11. 1917, to Sept. 4 1917. that I saw her alive on Sept. 4 1917, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Primary — Marasmus

Immediate — Exhaustion

(Duration).....yrs.....mos. 24 ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos. 24 ds.

(Signed) J. P. Stearns M. D.

Sept. 7, 1917. (Address) 506 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept. 7, 1917
20-UNDERTAKER	ADDRESS
J. L. Gross & Son	108 N. Howard

Important

Spec.—8-24-14—M. & T.—2000 Bks.

D 8243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D 8243

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 St Peter ST.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fritz Lapin

(Residence in Baltimore: No. 702 St Peter St.; 58 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 5 (Day), 1853 (Year)

7-AGE, 64 yrs. 7 mos. 1 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fritz Lapin

(Address) 702 St Peter St

15-

Filed SEP 8 1917, 191.....

Registrar.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-1-1917, to 9-6-1917, that I saw h m alive on 9-6-1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary) Oldage

(Duration) ¼ yrs. mos. da.

(Signed) J. Purdon L. M. D.

9-6-, 1917 (Address) 1570 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Trinity Cem

DATE OF BURIAL. Sept 9, 1917

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern

D 8244

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

170 D 8244

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2219 Canary Ct ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Seray Haas

(Residence in Baltimore: No. 2219 Canary Ct

St.: yrs. Lifelong Resident

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 4, 1901
(Month) (Day) (Year)

7-AGE, 15 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Martin Haas.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Annie M Appel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morton Haas

(Address) 2219 Canary Ct

15-

Filed....., 191....

Registrar.

CAUSE OF DEATH ... important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally shot himself with a Cal .7 Mc rifle shell

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Henry Grau Coroner. M. D.

9/7, 191.7 (Address) 1600 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, Sept 9, 1917.

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 N Mayo

Spec.—8-24-14—M. & T.—500 Blks.

D 8245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 8245

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 E. Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph D Carmen

(Residence in Baltimore: No. 2709 E. Chase St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH, May 1, (Month) (Day) 1837 (Year)

7-AGE, 80 yrs. 4 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 025
(b) General nature of industry, business, or establishment in which employed (or employer)..... Druggist

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, John R Carmen

11-BIRTHPLACE OF FATHER (State or Country), N. C

12-MAIDEN NAME OF MOTHER Elizabeth Delaney

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mattie Carmen wife

(Address) 2409 E. C. Chase St.

15-

Filed....., 191.....

Registrar.

SEP 8 - 1917 HERBERT C. ANDREWS DEPUTY CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1917, to Sept 6 1917, that I saw h- alive on Sept 6 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Cystitis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) James M Keuton M. D.

Sept 7, 1917 (Address) 709 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn | DATE OF BURIAL, Sept 9, 1917

20-UNDERTAKER Roberts & Turner | ADDRESS 1472 N Broadway

Important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8246 HEALTH DEPARTMENT—CITY OF BALTIMORE 126 ✓ D 8246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 2 Miss Lorkins Hos. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E. Tolson

(Residence in Baltimore: No. 1024 N. Wolfe St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Married

6-DATE OF BIRTH, March 1, 1851 (Month) (Day) (Year)

7-AGE, 66 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Odd

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. James Tolson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. E. Tolson

(Address) 1024 N. Wolfe St.

15- SEP 8 - 1917 HENRY C. ANDERS BUREAU OF VITAL STATISTICS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 27 1917, to Sept. 1 1917, that I saw h.. alive on September 1 1917, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Bacteria Dysentery (acute)

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) [redacted]

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Edward Pascal M. D.

Sept. 2, 1917. (Address) Johns Hopkins Hos.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 2 mos. 11 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1024 N. Wolfe St.

19-PLACE OF BURIAL, OR REMOVAL, Lorraine Cem. DATE OF BURIAL, Sept. 10, 1917.

20-UNDERTAKER Theodore White ADDRESS 113 S Wolfe

Important—See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

D 8247

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 ✓ D 8247

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 W Biddle St.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Woods

(Residence in Baltimore: No. 528 W Biddle St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Autumn (Month) (Day), 1853 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private family

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Edwards Woods

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Bettie Alexander

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Banks

(Address) 1628 W Biddle St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Sept 6 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Heart Failure

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 16 ds.

(Signed) L. G. W. Kerrigan M. D.

Sept 6, 1917. (Address) 708 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leakey P.C.

DATE OF BURIAL, Sept 7, 191.

20-UNDERTAKER Samuel Hensley

ADDRESS 5 E Biddle

Important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8248

CERTIFICATE OF DEATH.

104 D 8248

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 1105 Teach Alley St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter M. Gimbel

(Residence in Baltimore: No. # 1105 Teach. Alley. St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September 25th (Month) (Day), 1915 (Year)

7-AGE, 1 yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimor Md.

PARENTS.

10-NAME OF FATHER, Matthews Gimbel

11-BIRTHPLACE OF FATHER (State or Country), Hungary

12-MAIDEN NAME OF MOTHER Catherine Sendelbach,

13-BIRTHPLACE OF MOTHER (State or Country), Hungary.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Gimbel

(Address) # 1105 Teach. Alley.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 25 1917, to Sept 5 1917, that I saw h.m alive on Sept 5 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) .....yrs. .....mos. 15 ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(Duration) .....yrs. .....mos. 15 ds.

(Signed) Shepherd Dorsey M. D.

Sept 6, 1917 (Address) 1227 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross C.C. DATE OF BURIAL, Sept 8 1917.

20-UNDERTAKER E & B Harle. ADDRESS 115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8249

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8249

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Glover ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Lawson Holston

(Residence in Baltimore: No. 21 N. Glover St St.: ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 11th, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 25 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Howard H. Holston

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Nellie Cummings

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. H. Holston

(Address) 21 N. Glover St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 6 1917, that I saw h/m alive on Sept 6 1917, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) C. H. Meyer Jr M. D.

Sept 6, 1917 (Address) 26 E. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pleasant View

DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER Edw. W. Shaeffer

ADDRESS 1424 Mc Keyed. Ave

Important. See instructions.

Sept. 1917. Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D 8250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8250

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CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Port ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha May Sappington

(Residence in Baltimore: No. 509 N. Port St., Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 10, 1913
(Month) (Day) (Year)

7-AGE, 4 yrs. 2 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Charles E. Sappington

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bessie Bell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Sappington

(Address) 509 N. Port St

15-

Filed ....., 191.....
Registrar.

SEP 8 - 1917 ERNEST C. ANDERS Registrar Vital Statistics Dept. of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 6 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculus Pneumonia
(Only treated her one day.)

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) H. Kunz M.D.

Sept 7, 191 7 (Address) 604 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Friendship Cemetery

DATE OF BURIAL. Sept 8, 191 7

20-UNDERTAKER Christian Miller

ADDRESS 230 N Paca St

Important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 8251

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elise Wrishaar

(Residence in Baltimore: No. 2416 Jefferson St. Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Jan (Month) 16 (Day), 1896 (Year)

7-AGE, 21 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Wrishaar

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Christine Nissler

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Wrishaar

(Address) 2416 Jefferson

15-

Filed ..... SEP 9 1917, 191.....

ASHBY C. ANDREWS
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 191 7, to Sept 7 191 7, that I saw h er alive on Sept 7 191 7, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Edward Lyon M. D.

9/7, 191.. (Address) 413 N Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Trinity Cemetery	Sept 10, 1917
20-UNDERTAKER	**ADDRESS**
Christian Miller	20 Hanover St

B 8252

CERTIFICATE OF DEATH

37

REGISTERED No. C B 8252

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 111 S. Collington ave ST.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Cullison

(Residence in Baltimore: No. 111 S. Collington ave ST.: yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	infant

6-DATE OF BIRTH July 26, 1917 (Month) (Day) (Year)

7-AGE ..... yrs. One mos. 13 ds. | If LESS than 1 day ..... hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Arthur Ellsworth

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Grace Bell Cullison

13-BIRTHPLACE OF MOTHER (State or country) Va

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Belle Cullison

(Address) 111 S. Collington ave

15-

SEP 8 - 1917 HARRY O. ANDREWS

Filed ..... , 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 7, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1917, to Sept 7 1917, that I saw him alive on Sept. 7, 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. mos. ds

Contributory (SECONDARY) Anaemia

(Duration) yrs. mos. ds.

(Signed) Herman Siebert M. D.

Sept. 7, 1917 (Address) 1931 E. Pratt st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	9/8, 191 7.
20-UNDERTAKER Jack Lewis	ADDRESS 1911 E Baltimore

state CAUSE OF DEATH in plain terms, so that ... is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 8253

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Calverton Rd & Penn. R.R. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nehemiah Dyson

(Residence in Baltimore: No. 10 Wheeler Ave

St.: 57 yrs., 8 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, ... Jan. 4th, 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. 8 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: night watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Butchers abbatoir

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Myer Dyson

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Dyson

(Address) 2619 W Franklin St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull & mangled body by Train on Penn RR

(Duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James McFenton M. D.
(Coroner.)

Sept 6 1917 (Address) 709 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Odenton Md.	Sept 8, 1917.
20-UNDERTAKER	ADDRESS
Mr & Mrs John H. Tenzel	801 N. Fayette St

important. See instructions on back of certificate.

SEP 8 - 1917 HARRY O'NEILL

D 8251 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8251

+138

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md General Hospt St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie J. Sprecher.

(Residence in Baltimore: No. 205 Rockdale Ave Balto Co St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Jan. 10th, 1894
(Month) (Day) (Year)

7-AGE, 23 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Duties
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles Sieling

11-BIRTHPLACE OF FATHER (State or Country). Pa.

12-MAIDEN NAME OF MOTHER Elizabeth Chenoweth

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russel S. Sprecher

(Address) 205 Rockdale Ave

15- Balto Co.

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 6th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia
(Duration) hrs. mins. ds.
CONTRIBUTORY (Secondary) Fibroid of Uterus
(Duration) yrs. mos. ds.

(Signed) J. H. McCormac M. D.
(Coroner)
Sept 7, 1917. (Address) 8 E. Pleasant St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State 36 yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Sept 7, 1917.
20-UNDERTAKER	ADDRESS
Wm. & John H. Teufel	811 W. Fayette St.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8255

CERTIFICATE OF DEATH.

10 4 D 8255

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1920 Aliceanna ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jomina Szymanik

(Residence in Baltimore: No. 1920 Aliceanna, St.; ....yrs., 11 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Nov. 1, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Szymanik

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Szymanik

(Address) 1920 Aliceanna St.

15-

SEP 8-1917 ROBERT R. KRAUTER

Filed ....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 18 1917, to Sept 6 1917, that I saw her alive on Sept 6 24 1917, and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & Inanition

(Duration) ....yrs. ....mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Wm. D. Chadwick M. D.

Sept 8, 1917; (Address) 1625 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sept 9, 1917

20-UNDERTAKER William Hallowell

ADDRESS 616 Cemetery Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8256

CERTIFICATE OF DEATH.

79 D 8256

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Schroeder ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Walton

(Residence in Baltimore: No. 516 N. Schroeder St.; 75 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH, July (Month) 16 (Day), 1842 (Year)

7-AGE, 75 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Groceryman
(b) General nature of industry, business, or establishment in which employed (or employer): Proprietor Grocery Store

9-BIRTHPLACE, (State or Country), Manchester, England

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ric. Walton

(Address) 500 N. Stricker

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28 1916, to Sept. 7th 1917, that I saw him alive on Sept. 7th 1917, and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Uncertified)

(Duration) 1 yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) — yrs. — mos. 4 ds.

(Signed) E. Chas. Timmerer M. D.

Sept. 7th, 1917. (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park [redacted] DATE OF BURIAL, Sept. 10 1917.

20-UNDERTAKER Wilbur H. Shriver ADDRESS 101 [redacted] Ave

SEP 8 1917 ROBERT P. KRAUTER

Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

D 8257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Williams

(Residence in Baltimore: No. 735 Cumberland St St.; — yrs., 10 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 19, 1916
(Month) (Day) (Year)

7-AGE, — yrs. 10 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Williams

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Bessie Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Smith

(Address) Johns Hopkins Hospital

15-

Filed.....; 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 31 1917, to September 6 1917, that I saw h— alive on September 6 1917, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococcus)
Infection

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. M. Rieger M. D.

Sept 6, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 735 Cumberland St

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem 735 Cumberland St

DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 S Mt

Cross out words not important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

955
D 8258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93 D 8258

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 Ridgely Av. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Kraft.

(Residence in Baltimore: No. 1148 Ridgely Av St.; 47 yrs., 11 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 8 (Day), 1874 (Year)

7-AGE.	If LESS than 1 day,
47 yrs. 11 mos. 2 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE. (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Robert Parker.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lydia Watkins.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Kraft

(Address) 608 N. Fremont Av.

15- ROBERT B. KRAUTER

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1917, to Sept 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. 1 ds.

(Signed) C. H. Hammond M. D.

Sept 7, 1917. (Address) 835 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
~~Mt~~ Olivet	Sept. 9, 1917.
20-UNDERTAKER Wm Cook	ADDRESS 502 E. North

D 8259 HEALTH DEPARTMENT—CITY OF BALTIMORE 165 ✓ D 8259

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 519 W Barre. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona M. Smith

(Residence in Baltimore: No. 519 Barre. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, (Unknown), (Month) (Day) 1876 (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George Paton

11-BIRTHPLACE OF FATHER (State or Country), New York.

12-MAIDEN NAME OF MOTHER Mary A. McCook.

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Paton

(Address) 519 Barre

15-

Filed ....., 191.... ROBERT R. KRAUTHS Registrar.

SEP 8 1917 BUREAU OF VITAL STATISTICS

Cross out any word not important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bi Chloride poison taken by mistake. (accidental)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. S. Driscoll M. D. (Coroner.)

Sept 7, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Mt Carmel.	Sept 19.7.

20-UNDERTAKER	ADDRESS
Wm Lodge	502 E Watts

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8260

CERTIFICATE OF DEATH.

28 ✓ D 8260

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S. Poppleton St. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME Francis J. Huesman

(Residence in Baltimore: No. 328 S. Poppleton St. St.; 40 yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 11, (Month) (Day) 1 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Beef
(b) General nature of industry, business, or establishment in which employed (or employer): Driver

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Huesman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Huesman

(Address) 328 S. Poppleton St.

15-

Filed....., 191.....

ROBERT E. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 31 1917, to Sept 7 1917, that I saw him alive on Sept 5 1917, and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Contributory

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John E. O'Neill M. D.

Sept 8, 191.. (Address) 754 N. Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Sept. 10, 1917

20-UNDERTAKER John J. Cannon & Son ADDRESS 709 W. Hollins St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 8261

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2902 St Paul St. St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Stewart Polk.

(Residence in Baltimore: No. 2902 St Paul St. St.; 37 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, 22nd April, 22nd (Month) (Day), 1827 (Year)

7-AGE, 90 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Vice Prest. Business Corpn

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

9-BIRTHPLACE, (State or Country), Wash. D.C.

PARENTS.

10-NAME OF FATHER, David Peale Polk

11-BIRTHPLACE OF FATHER (State or Country) Alexandria Va

12-MAIDEN NAME OF MOTHER Letitia Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anderson Polk

(Address) 2902 St Paul St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) / 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/1 191 7, to 9/7 191 7, that I saw h~~im~~ alive on 9/7 191 7, and that death occurred, on the date stated above, at 10.26 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(Duration) 1 yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia (Hypostatic)

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) W. Stanley Gorsuch M. D.

9/9, 191 7 (Address) 2100 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Sept 9th, 1917

20-UNDERTAKER H.W. Jenkins Son & McCulloch ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D 8262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D 8262

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 Calow ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M. Hoeflich

(Residence in Baltimore: No. 315 Calow ave St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July 1, 1838
(Month) (Day) (Year)

7-AGE, 79 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Oring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phil. C. Hoeflich

(Address) 315 Calow Ave

15-

SEP 8 1917 ROBERT P. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Sept 6 1917, that I saw h alive on Sept 5 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .....yrs. 1 mos. .....ds.

CONTRIBUTORY. Cardiac Weakness
(Secondary)

..... (Duration) .....yrs. 2 mos. .....ds.

(Signed) C. E. Campbell M. D.

Sept 7 191 7 (Address) 16 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, BALTIMORE CEMETARY. DATE OF BURIAL, SEP 8 1917

20-UNDERTAKER ARMSTRONG-DENNY CO. ADDRESS 715 Light

Spec.—5-19-13—M. & T.—500 Bks.

D 8263

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 W D 8263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 413-415 N Biddle ST.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Alida Harcum

(Residence in Baltimore: No. 3109 Barclay St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 25, 1916 (Month) (Day) (Year)

7-AGE, yrs. 8 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Daniel Harcum

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Virginia L. William

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Harcum

(Address) 3109 Barclay St

15-

Filed SEP 8 - 1917, 191

ROBERT D. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Sept 7 1917, that I saw h[er] alive on Sept 7 1917, and that death occurred, on the date stated above, at 3:15 m.

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Hill M. D.

9-7-, 191 7 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Sept 9, 191 7

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W Fayette

D 8264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8264

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Little Sisters of Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Walsh.

(Residence in Baltimore: No. Little Sisters of Poor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	whi	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year) 1826

7-AGE 91 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Walsh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedicta

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

SEP 8 1917

ROBERT E. KRAUTH
Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) ..... 5 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Senility

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Acute Dilat. Heart

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner)

Sept 5, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER H. C. Wedefeld ADDRESS 914 Gilmore Av

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8265

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8265

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 S. Caste ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna, E. Mayer

(Residence in Baltimore: No. 140 S. Caste ave St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 27 (Day), 1917 (Year)

7-AGE, ...yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm. H. Mayer

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Bertha Bostwick

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Mayer

(Address) 140 S. East ave

15-

Filed....., 191.... Registrar.

ROBERT R. [illegible]
SEP 8 1917
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 6 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 6,0 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

(Signed) F. W. Langrein M. D.

Sept 7, 1917. (Address) 826 N. Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Sept 8th 1917

20-UNDERTAKER F. A. Krause ADDRESS 703 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

D 8266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 Clifton ave ST.; 15 WARD)

REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Welch

(Residence in Baltimore: No. 3610 Clifton ave St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April 14, 1844
(Month) (Day) (Year)

7-AGE, 73 yrs. 4 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Welch

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary P. Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Taylor

(Address) 1 York court

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2- 1917, to Sept 7 1917, that I saw her alive on Sept 7 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

"Chronic Nephritis"

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 2 mos. 5 ds.

(Signed) W. S. Welch M. D.

Sept 7, 1917. (Address) Garrison Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Sept 9, 1917

20-UNDERTAKER Pickler & Pickler ADDRESS 1739 E. Eager

Spec.—8-24-14—M. & T.—2000 Bks.

D 8267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8267

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Shakespeare ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Fisch

(Residence in Baltimore: No. 1602 Shakespeare St.: 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 10, 1853
(Month) (Day) (Year)

7-AGE, 59 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Pretzel Baker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Fisch

(Address) 1602 Shakespeare St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 191 7, to Sept 6th 191 7, that I saw h alive on 191 , and that death occurred, on the date stated above, at 7.10 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 5 mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 3 ds.

(Signed) Jno D Mullen M. D.

Sept 6th, 191 7 (Address) 1621 E Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Sept 9th, 1917.

20-UNDERTAKER J. Sander Sons — ADDRESS 1110 West St

D 8263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8263

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2924 Remington Ave ST.; W WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Murrell J. Smith

(Residence in Baltimore: No. 2924 Remington Ave St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. (Month) 15, (Day) 1917 (Year)

7-AGE, ... yrs. ..... mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Chas Smith

11-BIRTHPLACE OF FATHER (State or Country), Howard Co

12-MAIDEN NAME OF MOTHER Mary A. Ryan

13-BIRTHPLACE OF MOTHER (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Smith

(Address) 2924 Remington Ave

15-

Filed ....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 7, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D. (Coroner)

Sept 8 1917 (Address) 36 32 Belvedere

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Govd. DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER, A F Marshall ADDRESS, 559 Fallsway

CAUSE OF DEATH. Items 16 to 20 important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8269

CERTIFICATE OF DEATH.

150 D 8269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Exeter ST.; 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michaelangelo Tanzella

(Residence in Baltimore: No. 428 N Exeter St.; ....yrs. 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 22 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Vincen Tanzella

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Salvatrice Tartitta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincen Tanzella

(Address) 428 N. Exeter St.

15-

Filed....., 191....

Burial Permit ....

Registrar.

SEP 8 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5 1917, to Sept 8 1917, that I saw h alive on Sept 8 1917, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

Immaturity

(Duration) 2 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cleft Palate

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Valentine M. D.

Sept 8, 191.. (Address) 1618 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 428 N Exeter St

19-PLACE OF BURIAL OR REMOVAL. St Vincent Cemetery

DATE OF BURIAL, Sept 8, 191.7

20-UNDERTAKER S. Guinan + Bro

ADDRESS 107 E. Balto St

D 8270 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 8270

CERTIFICATE OF DEATH.

REGISTERED No. C 174

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Southern Hotel Dwelling ST.: 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elruby Robison (or Roberts

(Residence in Baltimore: No. 717 Gold St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, M. Robison or Roberts

11-BIRTHPLACE OF FATHER (State or Country), ~~Va.~~ Ga.

12-MAIDEN NAME OF MOTHER M. J. Pinnaky

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Roberts

(Address) 717 Gold

15-

Filed ....., 191.....

SEP 8 1917 ROBERT R. EBAUGH Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Track Skull
Crushed by Elevator accident
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) unknown
(Duration) yrs. mos. ds.

(Signed) W J Pelle (Coroner.) M. D.
Sept 8, 1917. (Address) 1657 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion
DATE OF BURIAL, Sept 9, 1917

20-UNDERTAKER Edward Ringgold
ADDRESS 1638 Pine

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8271 D 8271

CERTIFICATE OF DEATH.

15 40

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 E. Fort Avenue ST.; 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Jones

(Residence in Baltimore: No. 1308 E. Fort Avenue, St.; 32 yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, February (Month) 27th (Day), 1866 (Year)

7-AGE, 51 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer Works

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth J. Williams

(Address) 14 W. Montgomery Street.

15-

Filed....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 5th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 12th 1917, to Sept. 5th 1917, that I saw him alive on Sept. 4th 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) - yrs. 8 mos. - ds.

CONTRIBUTORY (Secondary) - - -

(Duration) yrs. mos. ds.

(Signed) Edw. M. Shedrick M. D.

Sept. 6, 1917. (Address) 5 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light

Important: Be sure to answer all questions.

SEP 8 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 8272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8272

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8375 Bond ST. V WARD) REGISTERED NO. C

2-FULL NAME Teresa Smiada (Teresa Smiada)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 137 S. Bond St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. 16, 1917.
(Month) (Day) (Year)

7-AGE, yrs. 6 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jan Smiada

11-BIRTHPLACE OF FATHER (State or Country), Russia Polland

12-MAIDEN NAME OF MOTHER Katarzyna Zielinska

13-BIRTHPLACE OF MOTHER (State or Country), Russia Polland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Smiada

(Address) 137 S. Bond St

15-

Filed SEP 8 1917, 191.. HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1917, to Sept 7 1917, that I saw her alive on Sept 7th 1917, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Sepsis Colitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Wm. N. Bullock M. D.

Sept 8, 1917. (Address) 1626 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept. 7, 1917.

20-UNDERTAKER, Jacob Frail Kowski — ADDRESS 928 S. Bond St.

D 8273

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 D 8273

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S Green St. W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilian Senkus

(Residence in Baltimore: No. 122 S Green St.; yrs. 10 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: November 4 [illegible], 1916 (Month) (Day) (Year)

7-AGE: yrs. 10 mos. 4 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Nil
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: Vincent Senkus

11-BIRTHPLACE OF FATHER (State or country): Lithuania

12-MAIDEN NAME OF MOTHER: Anna Bulot

13-BIRTHPLACE OF MOTHER (State or country): Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vincent Senkus

(Address) 122, So, Green, Str,

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 1917, to Sept 7, 1917, that I saw h[illegible] alive on Sept 7, 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(Duration) yrs 1 mos 7 ds.

Contributory (SECONDARY) Pneumonia (Broncho)

(Duration) yrs mos 4 ds.

(Signed) Alfred Whitehead M. D.

1917 [Address] 1213 Madison

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Sept 10, 1917

20-UNDERTAKER: John Grebliunas

ADDRESS: 935 S Paca St

SEP 8 - 1917

HARRY G. JACOBS

REGISTRAR

STATE CAUSE OF DEATH in plain terms. DO NOT USE TERMS OF DISEASE, but state the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. See instructions on back of certificate. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

D 8274

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.) 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson Carlisle

(Residence in Baltimore: No. 332 N. Front St.)

St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	single

6-DATE OF BIRTH, June 8, (Month) (Day) 1917. (Year)

7-AGE, ...yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Walter Carlisle

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jessie Elwell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed SEP 8 1917 HERBERT C. ANDREWS DEPUTY REGISTRAR, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 7 191 , to September 8 191 , that I saw him alive on September 8 191 , and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-enterostomy

indigestion acute

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Conrad M. D.

Sept 8 191 7. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 332 N Front St

19-PLACE OF BURIAL OR REMOVAL Mt Cosmel City DATE OF BURIAL Sept 10 191 7

20-UNDERTAKER Ed Byrne ADDRESS 202 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D 8275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 28

D 8275

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Young

(Residence in Baltimore: No. Univ. Hospt. St.; ..... yrs., ... mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1920 (Year)

7-AGE,	If LESS than 1 day,
37 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record.

(Address) .....

15-

Filed SEP 8 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) ..... 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1917, to Sept. 7, 1917, that I saw her alive on Sept. 7, 1917. and that death occurred, on the date stated above, at 11 10 m.

The CAUSE OF DEATH* was as follows:

....Pulmonary tuberculosis

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B B Brannon M. D.

Sept. 7, 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 25 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence Bryantown Md.

19-PLACE OF BURIAL, OR REMOVAL, Waldorf Md. DATE OF BURIAL, Sept 9, 1917

20-UNDERTAKER E & B Nash ADDRESS 115 E Next St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 8276

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N Pulaski St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Nicholson

(Residence in Baltimore: No. 525 N. Pulaski St.; 5 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED;~~ (Write the word.): Married

6-DATE OF BIRTH: May 14, 1870 (Month) (Day) (Year)

7-AGE: 47 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0'3

9-BIRTHPLACE, (State or Country): Bellaire Ohio.

PARENTS.

10-NAME OF FATHER: John Kleber

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Schick

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Wm S Nicholson

(Address) 525 N Pulaski St.

15-

Filed....., 191...

ROBERT A. KRAUTER

SEP 8 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8th, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov 26th 1916, to Sept 8th 1917, that I saw h[illegible] alive on Sept 7th 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart

(Duration) ....yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis Endocarditis

(Duration) ?....yrs. ....mos. ....ds.

(Signed) Chas R. McKinney M. D.

Sept 8, 1917. (Address) 520 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bellaire Ohio — DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER Geo. A. Corby — ADDRESS Baltimore

56

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8277. ✓ 151 D 8277.

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jenny Lind ST.: it WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orville Buntor Weaver

(Residence in Baltimore: No. Attaulie, Va. St.; ....yrs., 4 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Sing'l

6-DATE OF BIRTH, ..., 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Kendall Weaver

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah Buntar

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Stevenson

(Address) 2001 Maryland Ave

15-

Filed....., 191..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-1-17 191.., to 9-8 191.7, that I saw h.. alive on 9-8 191.7, and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

I
Pneumonia
.....
.....
(Duration) ....yrs. 7 ....mos. ....ds.

CONTRIBUTORY (Secondary) None
(Duration) ....yrs. ....mos. ....ds.

(Signed) Neil Hoy M. D.

9/8, 191.7. (Address) Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Attaulie, Va

19-PLACE OF BURIAL OR REMOVAL, Attaulie Virginia — DATE OF BURIAL, Sept 9, 1917.

20-UNDERTAKER Geo. A. Gerber — ADDRESS Balto & Hayes

86

Important: Use Indelible Ink.

D 8278

Elizabeth Daniel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8278

CERTIFICATE OF DEATH.

104 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 205 Lewis St. WARD)

2-FULL NAME Elizabeth Daniel

(Residence in Baltimore: No. 205 Lewis St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Baby

6-DATE OF BIRTH, Dec 15, 16
(Month) (Day) (Year)

7-AGE, 9 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Baby
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Daniels

11-BIRTHPLACE OF FATHER (State or Country), Va,

12-MAIDEN NAME OF MOTHER Lucinda

13-BIRTHPLACE OF MOTHER (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Clement

(Address) 209 Lewis

15-

Filed SEP 9 1917 191 ROBERT R. KRAUTH Registrar.

Burial Permit

CAUSE OF DEATH. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M.D.
(Coroner.)

Sept 8, 191 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Sept 9, 1917

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 East 4

Spec.—8-24-14—M. & T.—2000 Blks.

Letter in file from Mrs Lewis Lindstein dated July 1-1947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8279

CERTIFICATE OF DEATH.

18

D 8279

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital NV ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gilden

(Residence in Baltimore: No. 810 S. Charles St.; 24 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7-AGE. 48 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Candy Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country). Galiezien Russia Austria

PARENTS.

10-NAME OF FATHER. William Gilden

11-BIRTHPLACE OF FATHER (State or Country). Galiezien Russia Austria

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Galiezien Russia Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sons

(Address) 1411 E Baltimore St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 8 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 13, 1917, to Sept 8 1917, that I saw h im alive on Sept 8 1917 and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) 10 yrs. mos. 15 m da.

(Signed) Israel Strauss Co. M. D.

Sept 8, 1917 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 25 da. In the State 24 yrs. mos. da.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 810 Charles St

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL. 9/9, 1917

20-UNDERTAKER Jack Levis

ADDRESS 1411 E Balto St

ROBERT R. CRAWFORD
Burial Permit Clerk

July 1-1927
July 1-1929

I, Jack Lewis hereby make oath on this 30th day of June 1927. that in repoting the death of Joseph Gilden, I reported him being born in Russia, and it should had been born in Galiezien , Austria.

Jack Lewis

D 8279

State of Maryland
City of Baltimore

To Wit ;- On this 30th day of June 1927 apperaed Jack Lewis and made oath in due form of law taht the above statement is true anf bona-fide.

Morris Bryat
Notary Public

My Commission expires May 6th, 1929

Spec.—8-24-14—M. & T.—2000 Blks.

D 8280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8280

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Hebrew Hosp. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Baby Dairdourit

(Residence in Baltimore: No. 906 aisguith st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) —

6-DATE OF BIRTH, 9/8/17 (Month) (Day) , 1 (Year)

7-AGE, — yrs. — mos. — ds.

If LESS than 1 day, 1½ hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... NO .....

9-BIRTHPLACE, (State or Country), Hebrew Hosp

PARENTS.

10-NAME OF FATHER, Harry Dairdourit

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dora Gradsky

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr J Kats

(Address) Hebrew Hosp

15-

Filed ....., 191.... ROBERT R. KRAUTH Registrar.

Burial Permit Issued SEP 9 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/8 (Month) (Day) , 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/8/17 191 , to 9/8 191 , that I saw h[illegible] alive on 2:30 am 9/8 191 , and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Traumatic Birth Injury

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J Kats M. D.

9/8, 191 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew mt Cosmel	9/9, 191.7
20-UNDERTAKER	**ADDRESS**
Jack Levis	1411 E Balto

Spec.—8-24-14—M. & T.—2000 Blks.

D 8281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8281

CERTIFICATE OF DEATH.

135

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Davidovich

(Residence in Baltimore: No. 906 Aisquith St. St.: 12 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. May 5, 1 (Month) (Day) (Year)

7-AGE, 8 yrs. — mos. — da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Aaron Greenberg

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Celia Hoffman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. J. Roth

(Address) Hebrew Hosp.

15-

Filed 9/8/17, 191.. ROBERT P. STRAUSS Registrar.

Burial Permit [illegible]

SEP 8 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/8/17, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/8 191.., to 9/8 191.., that I saw h.r alive on 9/8 191.., and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as followa:

Pleurita Purna (Pulmonary)

(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) Second Hemorrhage

Pneumonia (Duration) ....yrs....mos....da.

(Signed) D. J. Roth M. D.

9/8, 191.. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 5 days in the State 12 yrs. mos. da.

Where was disease contracted, if not at place of death? at home

Former or usual residence 906 Aisquith St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, 9/10, 191..

20-UNDERTAKER Jack Levis

ADDRESS 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8282 D 8282

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 E 31 St ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Woodrow Eatman

(Residence in Baltimore: No. 718 E 31 St St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 17, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Karl Eatman

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Katharine Hollister

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Moore

(Address) 718 E 31 St.

15-

SEP 9 - 1917 ROBERT R. KRAUTER

Filed....., 191..... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep. 8 1917, to Sep 9 1917, that I saw h[im] alive on Sep 8 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gastro Intestinal

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Watson M. D.

Sep 8, 1917. (Address) 718 E St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery — DATE OF BURIAL, Sept 10, 1917.

20-UNDERTAKER J Kruig & Co — ADDRESS 2008 Orleans

D 8283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 8283

REGISTERED NO. C.

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1216 S. Paca ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Stanford

(Residence in Baltimore: No. 1216 S. Paca St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Charwoman
(b) General nature of industry, business, or establishment in which employed (or employer): D&C

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John P. Abell

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary E. Wyle,

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stewart Abell

(Address) Montgomery Co.

15-

Filed ....., 191.....
Registrar.

SEP 9- 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage Caused by excitement following a quarrel with her husband.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A L Driscoll M. D.
(Coroner.)
Sept 8, 1917. (Address) 372 W Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Sept 10 1917
20-UNDERTAKER	ADDRESS
The Falls Road Co.	3 E Lexington St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 D 8284

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. Glover ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Reitz

(Residence in Baltimore: No. 713 S. Rose 713 Glover St.; 1 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Sngl

6-DATE OF BIRTH, Dec 10, 1915 (Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles A. Reitz

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mamie Wiesner

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George A. Reitz

(Address) 713 S. Glover

15-

Filed....., 191.....

ROBERT R. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Sept 8 1917, that I saw h[illegible] alive on Sept 8 1917, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. 0 mos. 1 ds.

(Signed) H. Langworthy M. D.

Sept 8, 1917. (Address) 2431 East Fa

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem

DATE OF BURIAL, Sept 10, 1917

20-UNDERTAKER Jos. J. Kerr

ADDRESS 156 N. Luzerne

Spec.—5-19-13—M. & T.—500 Bks.

D 8285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 D 8285

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 Scott St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Tracey

(Residence in Baltimore: No. 1144 Scott St St.: 41 yrs. 4 mos. 3 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 4 (Day), 1876 (Year)

7-AGE, 41 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Goe, Kramaer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henrietta Sparenberg

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam. H. Tracey

(Address) 1144 Scott St

15-

ROBERT R. TRAUTZ

Filed SEP 9- 1917, 191.... Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1912, to Sept 7 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 5.40 A.M. [illegible] m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Puerperal Eclampsia

(Duration) Unknown mos....ds.

Sudden

(Signed) Edw. Gramaer M. D.

9.8.17, 191... (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Sept. 7, 191. 7

20-UNDERTAKER Mrs Thos Jno W. Lenfel — ADDRESS 801 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 Oakland St.; 7 WARD)

REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank G. Pizzuola

(Residence in Baltimore: No. 2327 Oakland St.; yrs., 1 mos. 2 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, ... (Month) May (Day) 6, (Year) 1917

7-AGE, ... yrs. 1 mos. 2 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, James Pizzuola

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Blaha

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Pizzuola

(Address) 2327 Oakland St.

15-

Filed ....., 191.....

SEP 9 1917 ROBERT R. KRAUTER Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Sept (Day) 8, (Year) 1917.

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 8 1917, that I saw h in alive on Sept 8 1917, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Malignant Endocarditis

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. S. Runge Jr M. D.

Sept 9, 1917 (Address) 604 N Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Sept 10, 1917.

20-UNDERTAKER Frank Cracknon | ADDRESS 1906 Eastern

Important

Spec.—8-24-14—M. & T.—2000 Bks.

D 8287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 D 8287

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 S Luzley St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sofie P. A. Hylla

(Residence in Baltimore: No. 717 S Luzley St. 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 25, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Emil Hylla

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Lang

13-BIRTHPLACE OF MOTHER (State or Country), Hungarian

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Hylla

(Address) 717 S Luzley St

15-

SEP 9- 1917 ROBERT R. KRAUTH Burial Permit

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1917, to Sept 1 1917, that I saw h is alive on Aug 26 1917, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Measles

..... (Duration) yrs. mos. 8 ds.

(Signed) W. H. Luzley M. D.

Aug 26, 191.. (Address) 434 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart

DATE OF BURIAL, Sept 3, 191..

20-UNDERTAKER H. Beck

ADDRESS 502 E Nathan

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8288 — 31 — D 8288

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Bank ST.; V WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margareth Studzynski

(Residence in Baltimore: No. 1916 Bank St.; yrs., 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ~~Dec~~ December 5, 1916 (Month) (Day) (Year)

7-AGE, yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Andrew Studzynski

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Antonette Dombeck

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Studzynski

(Address) 1916 Bank St.

15-

SEP 9 - 1917 ROBERT R. KRAUTER

Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept. 8 1917, that I saw her alive on Sept 7 1917, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Cerebral)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis of the Intestines (Duration) yrs. mos. few ds.

(Signed) John H. Rehlinger M. D.

Sept. 8, 1917. (Address) 1709 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Sept. 9, 1917.

20-UNDERTAKER Lilly Zeiler ADDRESS 403 S. Wolfe

Important. See instructions on reverse side.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8289

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 8289

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 N Gilmor St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina M Schroeder

(Residence in Baltimore: No. 728 N Gilmor St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, January 24, 1840 (Month) (Day) (Year)

7-AGE, 77 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER. Philip Pfeffer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Konow

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav Schroeder

(Address) 728 N Gilmor St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1917, to Sept 7 1917, that I saw her alive on Sept 7 1917, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Homer C. Todd M. D.

Sept 8., 1917. (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, Sept 10, 191.7

20-UNDERTAKER H Rudolph Son | ADDRESS Town

Dr. Todd 735 N Fulton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8290

CERTIFICATE OF DEATH.

120

D 8290

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Frederick Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Steinacker

(Residence in Baltimore: No. 2911 Frederick Ave St.; 79 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 19 (Day), 1838 (Year)

7-AGE, 79 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Wm Holmes.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Mannro

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Steinacker

(Address) 2911 Frederick Ave.

15-

Filed SEP 9- 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 6 1917, that I saw her alive on Sept 6 1917, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows: Chronic parenchymatous nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of the lungs

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

Sept 9, 1917 (Address) 904 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Sept 11, 1917
20-UNDERTAKER H. J. McKnew & Son	ADDRESS Penna Ave

Important. To be filled out by Undertaker.

4 Pound [illegible] 2 71 Lombard

Spec.--8-24-14—M. & T.—2000 Bks.

D 8291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8291

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 N. Duncan ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Ruby

(Residence in Baltimore: No. 134 N. Duncan St.; ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 4, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles A. Ruby

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Hupka

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles A. Ruby

(Address) 134 N. Duncan St

15-

SEP 9 1917 ROBERT E. KRAUTH

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917 to Sept 8, 1917 that I saw h[illegible] alive on Sept 7, 1917, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis Colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. J. Peters M. D.

Sept 8, 1917. (Address) 1 West Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill Cemetery	Sept 9, 1917.
20-UNDERTAKER Winston Miller	ADDRESS [illegible]

Important. See instructions on back of this sheet.

D 8292 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8292

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Granville Hall.

(Residence in Baltimore: No. Cheltenham Prince Georges Co. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White.	Single

6-DATE OF BIRTH, Sept 13, 1897
(Month) (Day) (Year)

7-AGE, 19 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Brakeman on Car
(b) General nature of Industry, business, or establishment in which employed (or employer). W. B. & A. Electric R.R.

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William A. Hall

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Brady

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Hall

(Address) Cheltenham Prince Geo. Co.

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock following injuries caused by being crushed between two cars, while coupling cars. Accident.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. D. Driscoll M.D. (Coroner.)

Sept 8, 1917. (Address) 312 W Carroll Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cheltenham Md	Sept 10, 1917
20-UNDERTAKER	ADDRESS
Geo. E. Frazier	802 Madison

CAUSE OF DEATH. Be particular and specific. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Dropsy," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Consumption," "Convulsions," "Paralysis," "Uremia," "Jaundice," "Childbirth," "Premature Birth," "Stillbirth," "Still-born," "Infantile Debility," "Marasmus," "Lockjaw," "Mortification," "Old Age," "Natural Causes," "Sudden," "Unknown," "Coma," "Blood Poisoning," "Septicemia," "Pyemia," "Septic Poisoning," "Septic Infection," "Malignant Disease," "Malignant Growth," "Malignant Tumor," "Malignant Cancer," "Malignant Abscess," "Malignant Ulcer," "Malignant Fever," "Malignant Inflammation," "Malignant Hemorrhage," "Malignant Consumption," "Malignant Convulsions," "Malignant Paralysis," "Malignant Uremia," "Malignant Jaundice," "Malignant Childbirth," "Malignant Premature Birth," "Malignant Stillbirth," "Malignant Still-born," "Malignant Infantile Debility," "Malignant Marasmus," "Malignant Lockjaw," "Malignant Mortification," 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"Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Stillbirth," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Still-born," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Infantile Debility," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Marasmus," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Lockjaw," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Mortification," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Old Age," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Natural Causes," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Sudden," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Unknown," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Coma," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Blood Poisoning," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Septicemia," "Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Malignant Pyemia," "Malignant Malignant Malignant Malign

Spec.—8-24-14—M. & T.—2000 Bks.

D 8293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D 8293

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Bethel ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Boles

(Residence in Baltimore: No. 106 S. Bethel St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 23 (Day), 1917 (Year)

7-AGE, ...yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Edward Boles

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Isabela Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella Boles

(Address) 106 S. Bethel St

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 8 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1917, to Sept 7, 1917, that I saw her alive on Sept 7, 1917, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

1. Marasmus

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Mother Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert F. Green M. D.

Sept. 8, 1917. (Address) 120½ Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, 9-10, 1917.

20-UNDERTAKER Theodore White

ADDRESS 113 S. Wolfe St

D 8291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8291

19 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 307 E 23rd ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Gorman

(Residence in Baltimore: No. 307 E 23rd St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, May 1862
(Month) (Day) (Year)

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Bolan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Gorman

(Address) 611 Gutman Ave

15- SEP 9 - 1917

Filed ....., 191.... ROBERT R. KRAUTH

Burial Permit ..... Registrar.

CAUSE OF DEATH is plain terms, as much as possible important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Chas. J. Morrison M. D.
(Coroner.)

Sept 7, 191.. (Address) 2332 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Sept 10, 1917
20-UNDERTAKER	ADDRESS
E. J. Wiechold	Green Ave

D 8295

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 D 8295

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2413 E. Preston ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and nomber and fill out No. 13.)

2-FULL NAME Anna M Kreer

(Residence in Baltimore: No. 2413 E Preston St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6-DATE OF BIRTH: November 1st, 1850 (Month) (Day) (Year)

7-AGE: 67 yrs. 10 mos. 7 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 67

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Francis A Kreer

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Anna M Huber

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Barbara Mathison

(Address): 2413 E Preston St

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 8th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1917, to, Sept 8th 1917, that I saw h.. alive on September 7 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency.

(Duration) yrs mos 3 ds.

Contributory (SECONDARY)

(Duration) yrs mos ds.

(Signed), Thos F. G Stevens M. D.

Sept 8, 1917 [Address] 2416 E Preston St.

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 11, 1917

20-UNDERTAKER: Henry Koch & Son — ADDRESS: 1362 E Eager St

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8296

CERTIFICATE OF DEATH.

92 D 8296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 178 W. Hamburg St.; 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Owens.

(Residence in Baltimore: No. 178 W Hamburg St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	Single

6-DATE OF BIRTH, Jan. (Month) 14 (Day), 188. (Year).

7-AGE, 30 yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jessie Owens.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary E. Davis

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma J. Johnson

(Address) 178 W Hamburg St

15-

Filed ....., 191.....

ROBERT B. KRAUTH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 7 (Day), 191 7. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 191 7, to Sept 7 191 7, that I saw h[im] alive on Sept 6 191 7, and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) J. Lucy Bowley M. D.

9/7/, 191 7 (Address) 136 W Hamburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct — DATE OF BURIAL, Sept 10, 191 7.

20-UNDERTAKER L. R. Brown & Son — ADDRESS 1711 Madison Ave

Important. Be particular to answer all questions.

SEP 10 1917
Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8297

CERTIFICATE OF DEATH.

D 8297

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REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 W North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest E. Nordenholz

(Residence in Baltimore: No. 1611 W North Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept (Month) 13 (Day), 1873 (Year)

7-AGE, 43 yrs. 11 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Liquor

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Albert Nordenholz.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Uhlbaun

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna M Nordenholz

(Address) 1611 W North Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1916 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 191 6, to Sept 6 191 7, that I saw h[illegible] alive on Sept 6 191 7, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Oesophagus)

..... (Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY Carcinoma

..... (Duration) ..... yrs. 8 mos. 12 ds.

(Signed) [illegible] M. D.

Sept 6, 191 7 (Address) 1611 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	Sept 10 191 7
20-UNDERTAKER W. J. Tuchner & Son	ADDRESS Penna Ave

SEP 10 1917 ROBERT R. KRAUTER Burial Permit Clerk

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8298 104 D 8298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Ames

(Residence in Baltimore: No. 4211 Euclid Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May 10th, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas J. Ames

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Catherine Doyle

13-BIRTHPLACE OF MOTHER (State or Country), Cork Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....; 191....

Registrar.

SEP 11 1917 ROBERT S. ERNSTER REGISTRAR OF VITAL STATISTICS

Important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1917, to Sept 9 1917, that I saw h alive on Sept 9 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion

(Duration) 0 yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Konrad M. D.

Sept. 9, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4211 Euclid Ave

19-PLACE OF BURIAL OR REMOVAL, Bonnie Blue Cemetery DATE OF BURIAL, Sept. 12, 1917.

20-UNDERTAKER W. J. Tuckness & Son ADDRESS North Ave

D 8299

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8299

Registered No. C 15 1

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 710 Singer Ave. St.; 13 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laurence H. L. Haynes

(Residence in Baltimore: No. 710 Singer Ave St.; yrs. 2 mos. 19 ds.)

N. B.—Every question must be answered. Write plainly with pen and ink. Use no abbreviations. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July (Month) 21 (Day), 1917 (Year)

7 AGE: yrs. 2 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Haines

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Elsie Meyers

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Haines

(Address) 710 Singer Ave

15.

Filed ..., 191 ...

REGISTRAR

ROBERT B. KRAUTH
SEP 10 1917
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 9 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1917, to. Sept 9 1917. that I saw him alive on Sept 9, 1917. and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Cerebritis

(Duration) yrs. 2 mos. 19 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R. C. Harlan M. D.

Sept 9, 1917 (Address) 3512 Forestmont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Mary's Pk.

DATE OF BURIAL: Sept 10, 1917

20 UNDERTAKER: A. J. Marshall

ADDRESS: 3537 Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

D 8300

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 228 E Church St, (ST.) (WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William albert Seger

(Residence in Baltimore: No.) 228 E Church St (If not in Baltimore, give State or Country.) (If a child, or under one year, give age in yrs., mos., ds.) 8 yrs 8 mos ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Sing

6-DATE OF BIRTH, August 4th, (Month) (Day) 1909 (Year)

7-AGE, yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Seger

11-BIRTHPLACE OF FATHER (State or Country), Prince Georges Md

12-MAIDEN NAME OF MOTHER Lottie Konski

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Seger

(Address) 228 E Church St

15- SEP 10 1917 ROBERT R. CRAUTH

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9th, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8th 1917, to Sept 9th 1917, that I saw h[illegible] alive on Sept 9th 1917, and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. F. O'Donnell M. D.

Sept 9th, 1917 (Address) 107 E 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenly — DATE OF BURIAL, Sept. 10, 1917

20-UNDERTAKER Will Cook — ADDRESS 602 E Northam

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8301 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 8301

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Linden Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph L. W. Reilly

(Residence in Baltimore: No. 918 Linden ave St.; 63 yrs., 2 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, June (Month) 15 (Day), 1854 (Year)

7-AGE, 63 yrs. 2 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Philip Reilly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Eliz. Fitzpatrick

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Reilly

(Address) 918 Linden ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 9 (Day), 1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 191 7, to Sept 9 191 7, that I saw h alive on Sept 8 191 7, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Contributed to by Cerebral Embolism

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Edward D. Magruder M. D.

....., 191... (Address) 918 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Sept. 11, 191 7.

20-UNDERTAKER W. Leaner Jones — ADDRESS 833 Linden ave

Important. See Instructions on Back of Certificate.

ROBERT R. KRAUTH SEP 10 1917 Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 W. Lafayette Ave ST.; 16 WARD)

REGISTERED NO. C 164 D 8302

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson Eduardo

(Residence in Baltimore: No. 2742 W. Lafayette Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, Nov 13, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bradford Edwards

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rosalie Spaeth

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Spaeth

(Address) 2742 W. Lafayette

15-

Filed....., 191.... Registrar.

SEP 10 1917 ROBERT R. [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1917, to Sept 8 1917, that I saw h... alive on Sept 7 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Gastro Enteritis

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Marked

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) John [illegible] M. D.

Sept 8, 1917. (Address) 1003 Johnson Square

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Sept 10, 1917.
20-UNDERTAKER	ADDRESS
Josiah Sykes	1600 W. North Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8303

CERTIFICATE OF DEATH.

D 8303

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1630 E Biddle St. 9 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V Walker

(Residence in Baltimore: No. 1630 Biddle St.; yrs., Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June 28, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. — mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) work,

9-BIRTHPLACE, (State or Country), Balto,

PARENTS.

10-NAME OF FATHER, William P Freman,

11-BIRTHPLACE OF FATHER (State or Country), md,

12-MAIDEN NAME OF MOTHER Anna Middleton

13-BIRTHPLACE OF MOTHER (State or Country), md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida Branch

(Address) 1630 Biddle

15- SEP 10 1917 ROBERT R. KNAUTH

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanosis Heart Disease,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D.K. Cowley M. D.
(Coroner.)

Aug 1, 1917. (Address) 11 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept 11, 1917

20-UNDERTAKER Chas E Evans & Sons ADDRESS 118 N Royal Ave

CAUSE OF DEATH must be plainly written, and all questions answered as far as possible. Every item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8304

CERTIFICATE OF DEATH.

79 D 8304

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade apts ST.; 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jonas Kaufman

(Residence in Baltimore: No. Esplanade apts ST.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~ (Write the word.)
Male	White	Married

6-DATE OF BIRTH, January 5, 1842
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 8 mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Bavaria Germany

PARENTS.

10-NAME OF FATHER, Isaac Kaufman

11-BIRTHPLACE OF FATHER (State or Country), Bavaria Germany

12-MAIDEN NAME OF MOTHER Babette Strauss

13-BIRTHPLACE OF MOTHER (State or Country), Bavaria Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Kaufman

(Address) Danville Va

15-

SEP 10 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1914, to Sept 9 1917, that I saw him alive on Sept 9 1917, and that death occurred, on the date stated above, at 9.15 A.M.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jos. L. Hirsh M. D.

....., 191... (Address) 2210 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bals Hebrew Cem	Sept 11, 1917

20-UNDERTAKER,	ADDRESS
L Sondheim	118 W Mt Royal Ave

D 8305

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 D 8305

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1424 Gough St. 3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jandmun Slotowz

(Residence in Baltimore: No. 1424 Gough St.; yrs. 8 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	child

6 DATE OF BIRTH Jan 17 (Month) (Day), 1917 (Year)

7 AGE ..... yrs. 1 mos. 21 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ..... child
(b) General nature of industry, business, or establishment in which employed (or employer) 660

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Slotowz

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Chaisara Kumar

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Levin

(Address) 1411 E Balto St

15

Filed SEP 10 1917, 191... ROBERT R. CRAUTZ Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 9 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1917, to Sept 9 1917, that I saw h.. alive on Sept 9, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Congenital heart Trouble
Failure to proper close of foramina ovalis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), M. V. [illegible] M. D.

....., 191... (Address) 17 Bl Eu Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Hebrew Nat Carmel | DATE OF BURIAL 9/10, 1917

20 UNDERTAKER Jack Levin | ADDRESS 1411 E Balto St

If DEATH occurred in a HOSPITAL or INSTITUTION, state CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE RECEIVED ..... It is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8306

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 8306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Hebrew Hospital St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Wasserstein

(Residence in Baltimore: No. 427 S Payson St.: 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1845 (Year)

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Chain Rugel

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balt St

15-

SEP 10 1917

Filed ....., 191.... ROBERT B. KRAUTH Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 9th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1917, to Sept 9th, 1917, that I saw her alive on Sept 9th, 1917, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene, R Leg (Amp. Calf)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 2 ds.

(Signed) M. Wasserstein M. D.

Sept 9th, 1917 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 427 S Payson St

19-PLACE OF BURIAL OR REMOVAL Hebrew Washington DATE OF BURIAL, 9/11/1917

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balt St

Important: See instructions on back.

D 8307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 D 8307

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 Carroll Av. ST. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Amy Taylor.

(Residence in Baltimore: No. 1410 Carroll Av St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7 AGE: 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John Taylor.

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Amy Taylor.
(Address) 1410 Carroll st.

15.
Filed SEP 10 1917, 191 ROBERT B. KRAUTER Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 7th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10, 1917, to Sept. 6 1917, that I saw h[illegible] alive on Sept 6 1917, and that death occurred, on the date stated above, at 1000 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY): Uterine Hemorrhage

(Duration) 1 yrs. mos. ds.

(Signed), Elizabeth Wynn M. D.

Sept 8, 191[illegible] (Address) 127 Columbia st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted. If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 10, 191[illegible]

20 UNDERTAKER: Bronner & Sieland — ADDRESS: 424 N. Schroeder st.

N. B. In order that it may be properly classified, so that CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8303

CERTIFICATE OF DEATH.

62 D 8303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Patterson

(Residence in Baltimore: No. 1619 Penna Ave St.: ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Wid

6-DATE OF BIRTH, Mar. (Month) 21 (Day), 1874 (Year)

7-AGE, 43 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) or 071

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Isaac Patterson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Lucinda Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp

(Address) Calvert & Fayette

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1917, to Sept 7, 1917, that I saw her alive on Sept 7, 1917, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ovarii

Do not know (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward H. Smith M. D.

Sept 7, 191 7. (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 2 mos. 2 ds. In the State 26 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1619 Pa. Ave.

Former or usual residence 1619 Pa. Ave.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 10 1917

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W Fayette St

Spec.—8-24-14—M. & T.—2000 Blks.

D 8309

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 8309

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 851 W. Lexington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Bungraf

(Residence in Baltimore: No. 851 W. Lexington St., St.: 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, March 7, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 6 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Wheelwright
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Bungraf

(Address) 418 Hilton St

15-

Filed ....., 191.....

Registrar.

SEP 10 1917 ROBERT B. KRAUTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 8 1917, that I saw h alive on Sept 8 1917, and that death occurred, on the date stated above, at 8 11/2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left side

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice E. B. Owens M. D.

Sept 8, 1917. (Address) 857 N. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 9-11, 1917.

20-UNDERTAKER H. C. Branning Son

ADDRESS 517 N. Schroeder St

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8310

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 N Fayette St. 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine O'Neill

(Residence in Baltimore: No. 946 N Fayette St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb (Month) 5 (Day), 1866 (Year)

7-AGE, 51 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Whitty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Julia White

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E R Tall

(Address) 946 N Fayette

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1917, to Sept 7 1917, that I saw h- alive on Sept 7 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Acute Intoxication

(Duration)....yrs....mos. 4 ds.

(Signed) E R Carbaugh M. D.

....., 191... (Address) 946 N Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, Sept 10, 191...

20-UNDERTAKER Geo F Johnson ADDRESS 1600 E Baltimore

Important. See instructions on back.

Spec.—5-19-13—M. & T.—500 Bks.

D 8311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 8311

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1054 N. Randall ST. 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Platt

(Residence in Baltimore: No. 1041 N Randall St.; ...yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Sept 7, 1917. (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, August Platt

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Laura Reif

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aug. Platt

(Address) 1041 N Randall St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 9, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 191 7, to Sept 9 191 7, that I saw h.m alive on Sept 9 191 7, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

6 mos. Prematurity
Inanition

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Sept 10, 1917
20-UNDERTAKER	ADDRESS
E. Sittmann and Son	1039 Hanover St.

Important. See instructions on reverse side.

D 8312

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8312

40

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1532 Light St. ST.: 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth F.Hartlove.

(Residence in Baltimore: No. 1532 Light St. St.: 76 yrs. 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow.

6-DATE OF BIRTH: July 23rd. 1841. (Month) (Day), 1 (Year)

7-AGE: 76 yrs. 1 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Charles K.Balla.

11-BIRTHPLACE OF FATHER (State or country): France.

12-MAIDEN NAME OF MOTHER: Catherine S.Dingleman.

13-BIRTHPLACE OF MOTHER (State or country): France.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs.Lizzie Hiss.(daughter)

(Address) 223 N.Fremont Ave.

15.

Filed ..... 191.. REGISTRAR

SEP 10 1917 Clerk

5

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 8th.1917. (Month) (Day), 191.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd. 1917, to, Sept,8th 1917, that I saw her alive on Sept,8th. 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver and Intestines./Clinical diagnosis.

(Duration) ... yrs. 3 mos. ... ds

Contributory (SECONDARY) Exhaustion. (Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.

Sept,8,1917. (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Sept 10, 1917.

20-UNDERTAKER: F. Fow McCully — ADDRESS: 130 E. Fort Ave

N. B.—Every item must be answered. State whether white, black, mulatto, quadroon or octoroon. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8313

CERTIFICATE OF DEATH.

151 D 8313

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1115 W. Hamburg ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Ringrose

(Residence in Baltimore: No. 1115 W Hamburg St.; ....yrs.,.... mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 12 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 600

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, George Ringrose

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Catherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert L. Ringrose

(Address) 1115 W. Hamburg St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 191.., to Sept 8 191.., that I saw h.. alive on Sept 8 191.., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration)....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Indigestion

(Duration).....yrs. 1 mos.....ds.

(Signed) Stephen Black M. D.

Sept 9, 191.. (Address) 12 S. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, Sept. 10, 1917

20-UNDERTAKER James Degnan & Son

ADDRESS 1000 S. Paca St

Important. Give instructions on other side of this sheet.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8314 64 D 8314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 1318 Druid Hill Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Cummings

(Residence in Baltimore: No. 1318 Druid Hill Ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Attorney at Law
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Mary Cummings

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Savage

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida E. Cummings

(Address) 1318 Druid Hill Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29- 1917, to Sept. 7 1917, that I saw h[illegible] alive on Sept. 6 1917, and that death occurred, on the date stated above, at 2:10 p.m.

The CAUSE OF DEATH* was as follows:

1. Coma

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. H. Tompkins M. D.

Sept 8, 1917 (Address) 1014 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 10, 1917

20-UNDERTAKER Samuel Feustel — ADDRESS 515 N Fremont Ave

Important: See instructions for completing this certificate.

SEP 10 1917 ROBERT E. LAZARUS CITY REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

D 8315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S Durham ST.; V WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Margaret Stefney

(Residence in Baltimore: No. 221 S. Durham St. St.; ....yrs,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. 10 ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 608

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Joseph Stefney

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Sadie Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Stefney

(Address) 221 S Durham st

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8..., 1917..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 6 1917, to Sept 8 1917, that I saw her alive on Sept 7 1917, and that death occurred, on the date stated above, at 7P a. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchio Pneumonia

.....

.....

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Frank J. Cyd M. D.

Sept 10, 1917. (Address) 1925 E. Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Sept. 10., 1917.
20-UNDERTAKER John W Henderson	ADDRESS 31 N Caroline

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8316

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH 2d Gen Hosp

CITY OF BALTIMORE: (No. Caroline & Orleans St.; ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Henry

(Residence in Baltimore: No. 1108 Bolton St; St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	M.

6-DATE OF BIRTH, ..., 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Joseph Henry

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mary Bolinger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Henry

(Address) 1108 Bolton St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1917, to Sept 10 1917, that I saw him alive on Sept 8 1917, and that death occurred, on the date stated above, at 1230 A m.

The CAUSE OF DEATH* was as follows:

Fractured Femur,
Fell out of Bed (Accident)
(Duration) yrs. 2 mos. ds.

CONTRIBUTORY. Hypostatic Cong.
(Secondary)
(Duration) yrs. mos. 3 ds.

(Signed) Henry Mitchell M. D.
....., 191... (Address) 20 F. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Went Known

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Sept....., 191..
20-UNDERTAKER	ADDRESS
Martin Fahey & Son	106 Lafayette Ave

Important. See instructions on back.

5

D 8317

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8317

CERTIFICATE OF DEATH

28

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 875 Linden Av ST.: 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Jackson

(Residence in Baltimore: No. 870 Linden Av. St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colored	Married

6-DATE OF BIRTH ..... December (Month) ..... 1 (Day) ..... (Year)

7-AGE 46 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Va

PARENTS

10-NAME OF FATHER Robert Proctor

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Maria Coleman

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Berry

(Address) 1521 Argyle Ave

15

Filed ..... SEP 10 1917 ..... 191 .....

REGISTRAR ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept (Month) 7 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1917, to Sept 7, 1917.
that I saw h.. alive on Sept 6, 1917.
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 1 ds

Contributory (SECONDARY) Tuberculosis Pulmonary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Kastens M. D.

Sept 7, 1917. (Address) 2008 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Leisure Co. | DATE OF BURIAL Sept 10, 1917.

20-UNDERTAKER Samuel Hawley | ADDRESS 5 S Eutaw

N. B.—Every item must be answered so that it may be properly classified. Leave nothing to be guessed at. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Leave nothing to be guessed at. Name of disease alone is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8318

CERTIFICATE OF DEATH.

28 D 8318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3125 Tunis Lane; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hynson Cassidy

(Residence in Baltimore: No. 3125 Tunis Lane St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 3, 1874
(Month) (Day) (Year)

7-AGE 43 yrs. 6 mos. 6 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, A Jackson Soller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary V. Hynson

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary V. Soller

(Address) 2114 Maryland Ave

15-

Filed ....., 191.... Registrar.

ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1917, to Sep 9 1917, that I saw h[illegible] alive on Sep 5 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. Tuberculosis mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. K. Ingram M. D.

Sep. 9, 1917. (Address) 2139 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. | In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral | DATE OF BURIAL, Sept ....., 191.7

20-UNDERTAKER F. C. Siedfeld | ADDRESS 914 Gay St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8319

CERTIFICATE OF DEATH.

104 D 8319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Penn Lucy ave & 38th St.; 9 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Pant

(Residence in Baltimore: No. Penn Lucy ave and 38th St.; ....yrs., ...mos. ....ds.)

(St. Elizabeth Home)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fmale	Col.	✓

6-DATE OF BIRTH. April 2, 1917
(Month) (Day) (Year)

7-AGE. ....yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE. (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (State or Country). ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country). ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Aug. 1917, that I saw her alive on Sept. 1917, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhea (Enteritis)

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Harry T. Collins M. D.

9-7, 1917. (Address) 2031 W Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL. ....., 191...
20-UNDERTAKER	ADDRESS

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8320

CERTIFICATE OF DEATH.

15 D 8320

REGISTERED NO. C.....

1-PLACE OF DEATH The Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Quill

(Residence in Baltimore: No. 1109 Carrollton ave. St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 4 (Day), 1917 (Year)

7-AGE, — yrs. — mos. — ds.

If LESS than 1 day, 5 hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer) ~ 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Quill.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Estelle Tate.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 4 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Sept 4 1917, that I saw her alive on Sept 4 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ~

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Edward L. Harris, M. D.

Sept. 5th 191.7. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

ROBERT E. LEE ... JOHNS HOPKINS HOSPITAL ... SEP 8 ... 1917 ... Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8321 — 104 — D 8321

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Stern

(Residence in Baltimore: No. 2042 Keyser St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 7 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Meyer Stern

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Ruth Harris

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 3 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from August 21 1917, to September 3 1917, that I saw h[er] alive on September 3 1917, and that death occurred, on the date stated above, at 6.20 p m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) - Malnutrition (Duration) ....yrs. ....mos. 21 ds.

(Signed) Henry J. Conard M. D.

Sept 3, 191.. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? "

Former or usual residence 2042 Keyser St

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

Important. Sections 12 and 13 of the Act require that a Certificate of Death shall be filed with the Registrar of the district in which the death occurs, before a burial or removal permit shall be issued.

SEP 10 1917 — JOHNS HOPKINS HOSPITAL — ROBERT E. KRAUTH — Commissioner of Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8322

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D 8322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Coffen

(Residence in Baltimore: No. 1213 Brentwood Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, December 24, 1916
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Frank Coffen

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Theresa Rudolf

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 5 1917, to September 5 1917, that I saw h^ alive on September 5 1917, and that death occurred, on the date stated above, at 12 05 p m.

The CAUSE OF DEATH* was as follows:

Liv - Colitis

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

None (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B. Conrad M. D.

Sept 5, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1216 Brentwood Ave

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

Important. See instructions on back of Certificate.

SEP 6 1917
JOHNS HOPKINS HOSPITAL
ROBERT R. KRAUTER
Burial Permit Clerk
Commissioner Health

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8323

D 8323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Penn Lucy Ave & 38th St.; 9 WARD) REGISTERED NO. C 1044

2-FULL NAME Georgia Annie Davis

(Residence in Baltimore: No. Penn Lucy Ave & 38th St. (St. Elizabeth Home); ..... St.; ..... yrs., ... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) ✓

6-DATE OF BIRTH, Oct. (Month) 1 (Day) 1916 (Year)

7-AGE, ... yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 088

9-BIRTHPLACE, (State or Country), ✓

PARENTS.

10-NAME OF FATHER, ✓

11-BIRTHPLACE OF FATHER (State or Country), ✓

12-MAIDEN NAME OF MOTHER ✓

13-BIRTHPLACE OF MOTHER (State or Country), ✓

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed SEP 10 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 6 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from ..... 191?, to ..... 191?, that I saw her alive on Aug. 5 191?, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

.....

Summer Diarrhea (Enteritis)

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) 9 yrs. ..... mos. ..... ds.

(Signed) Harry Goldberg M. D.

9-7-, 1917. (Address) 2031 W Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

Important. See instructions on reverse side.

ROBERT R. FRAUTS
Burial Permit Clerk

D 8321

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 8321

CERTIFICATE OF DEATH

120

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 56 E Baltimore St.; 23 Ward)

2-FULL NAME John M Brennan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 56 E Baltimore St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Sept 9th (Month) (Day), 1857 (Year)

7-AGE: 59 yrs. 11 mos. 29 ds. If LESS than 1 day, ... hrs., or ..... mm.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

218

9-BIRTHPLACE (State or country): Dorchester Co. Md

PARENTS

10-NAME OF FATHER: John Brennan

11-BIRTHPLACE OF FATHER (State or country): Dorchester Co Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred R Burns

(Address) 54 Catalba Ave

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 8th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1917, to Sept 8th 1917, that I saw h[illegible] alive on Sept 7th 1917, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) — yrs 6 mos. — ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) John M Brennan M. D.

Sept 10th, 1917 [Address] 1218 Eutaw

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Sept 10, 1917

20-UNDERTAKER: Mrs J E Evans & Son — ADDRESS: 1420 S Charles

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8325 104 D 8325

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Pearl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nunzio Amadore

(Residence in Baltimore: No. 412 Pearl St.; yrs., 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb. 3rd, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, Victorio Amadore

11-BIRTHPLACE OF FATHER (State or Country), Italy -

12-MAIDEN NAME OF MOTHER Mazzarena Pace

13-BIRTHPLACE OF MOTHER (State or Country), Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victorio Amadore

(Address) 412 Pearl St -

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 — 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9 — 7 1917, to 9 — 9 1917, that I saw h[illegible] alive on 9 — 9 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro intestinal
Infection

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) S. D. Russano M. D.

Sept. 10, 1917 (Address) 1.6.0.F. Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, Sept. 10 191.7

20-UNDERTAKER George J. Reuth

ADDRESS 1732 Harford Ave.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8326

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

151 D 8326

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Oak ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest D. Brooks

(Residence in Baltimore: No. 3428 Oak Ave St.: yrs., mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Aug. 21, 1917.
(Month) (Day) (Year)

7-AGE, ..yrs. ..mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balt. City

PARENTS.

10-NAME OF FATHER, Robt. L. Brooks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ford

(Address) 3428 Oak Ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19th, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28th 1917, to Sept 9 1917, that I saw h im alive on Sept 9th 1917, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..yrs. ..mos. 16 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) J. A. Tillett M. D.

Sept 10, 191.. (Address) 1127 Lumsden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys Hampden DATE OF BURIAL, Sept 9 11, 1917.

20-UNDERTAKER Dunworth & Son ADDRESS 1361 Chestnut Ave

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8327

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Puritan St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Ralph & Lillian Williams

(Residence in Baltimore: No. 724 Puritan St.; St.; 45 Minutes yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant.

6-DATE OF BIRTH, Sept 9, 1917. (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 45 min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of Industry, business, or establishment in which employed (or employer) 00

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, Ralph L. Williams

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Lillian Gregg

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph L. Williams

(Address) 724 Puritan St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1917. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Sept 9 1917, that I saw h alive on Sept 9 1917, and that death occurred, on the date stated above, at 10:27 m.

The CAUSE OF DEATH* was as follows:

Atrophy Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY Convulsions (Secondary) 8 hours

(Duration) yrs. mos. ds.

(Signed) R. B. Norment M. D.

9-9-, 1917. (Address) 3543 Westwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Frederick — DATE OF BURIAL, 9-10-, 1917.

20-UNDERTAKER Ensworth & Son. — ADDRESS

Impossible to read the writing on back of this certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Copy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8328

CERTIFICATE OF DEATH.

28

D 8328

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 791 N Mulberry St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilbert Smith

(Residence in Baltimore: No. 791 Mulberry St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1888 (Year)

7-AGE, 29 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Wyoth New Buildings

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Dunnock

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Roberts

(Address) 791 Mulberry

15-

Filed SEP 10 1917, 191.....

ROBERT R. KRAUTHE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 191 7, to Sept 8 191 7, that I saw h[illegible] alive on Sept 6 191 7, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ? yrs. ....mos. ....ds.

(Signed) William E Burton M. D.

Sept 8, 191 7 (Address) 712 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt. Auburn

DATE OF BURIAL, Sept 10, 191 7

20-UNDERTAKER Daniel Easton

ADDRESS 916 Lanvale St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8329

CERTIFICATE OF DEATH.

6 D 8329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 Sargent St- ST.; 21 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Grover Cleveland Bell

(Residence in Baltimore: No. 1153 Sargent St- St.; 2 yrs., 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. March 21st, 1915
(Month) (Day) (Year)

7-AGE. 2 yrs. 5 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER. James E. Bell

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Augusta Seifert

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Augusta E. Bell

(Address) 1153 Sargent St-

15-

SEP 10 1917

Filed.....; 191.....

ROBERT R. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 8 1917, that I saw h w alive on Sept 7 1917, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thurlow Davis M. D.

Sept 8, 191.. (Address) 122 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Sept. 10, 1917

20-UNDERTAKER John J. Doran & Son ADDRESS 409 Hollins St

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8330

CERTIFICATE OF DEATH.

9 2

D 8330

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 116 S. Castle ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Buettner

(Residence in Baltimore: No. 116 S. Castle St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH. Dec. 12, 1880
(Month) (Day) (Year)

7-AGE. 37 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Jeweler.
(b) General nature of industry, business, or establishment in which employed (or employer). 136

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Gotlieb Buettner

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Teresa Stork

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gotlieb Buettner

(Address) 116 S. Castle St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 8, 191 7
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1917, to Sept 8 1917, that I saw her alive on Sept 7 1917, and that death occurred, on the date stated above, at 10 5 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) H. R. Barnes M. D.

Sept 10, 191 7 (Address) 2008 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Sept. 11, 191 7.

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificate.

FILED SEP 10 1917 ROBERT R. KRAUTER Official Registrar

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Ann ST.; 7 WARD)

REGISTERED NO. C D 8331

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine A. Sandy.

(Residence in Baltimore: No. 311 S. Ann St.; 69 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 19th, 1 (Month) (Day) (Year)

7-AGE, 69 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 169

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Samuel Rayme

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Susan Toans.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Sandy

(Address) 311 S. Ann St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 9 1917, that I saw her alive on Sept 9 1917, and that death occurred, on the date stated above, at 2 45 m.

The CAUSE OF DEATH* was as follows:

Intus Uterus

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chron Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. W. Bamberger M. D.

Sept 10, 1917. (Address) 160 Bentz

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Sept 11, 1917.

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S Wolfe

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

D 8332

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5446 E. Clement ST.; 24 WARD) REGISTERED NO. C.....

2-FULL NAME John Christian Lipp

(Residence in Baltimore: No. 5446 E. Clement. St.; Lipp yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. September 24, 1853 (Month) (Day) (Year)

7-AGE. 63 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Lipp.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carrie Carver

(Address) 5344 E. Clement St.

15-

Filed ....., 191.... HARRY O. ANDERS CITY REGISTER Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb. 24 1917, to Sep. 9, 1917, that I saw him alive on Sep. 8, 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ...yrs. 7 mos. ...ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ...yrs. ...mos. ...ds.

(Signed) Albert J. Chambers M. D.

Sept. 9, 1917. (Address) 1012 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Sept. 11, 1917
20-UNDERTAKER F. A. Krause	ADDRESS 703 Hanover

Spec.—8-24-14—M. & T.—2000 Blks.

D 8333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 8333

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Saratoga ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred A. Chapman

(Residence in Baltimore: No. 1100 Saratoga St.; 27 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, DIVORCED. (Write the word) Married

6-DATE OF BIRTH, Oct. 29, 1889 (Month) (Day) (Year)

7-AGE, 27 yrs. 10 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS:

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER May Barton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Chapman

(Address) 1100 W. Saratoga St.

15-

Filed ....., 191...

SEP 10 1917 HARRY C. ARENDS

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Sept 10 1917, that I saw her alive on Sept 10 1917, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Blackwell M. D.

9/10, 191.. (Address) 1127 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	....., 191...
20-UNDERTAKER Robert Brockman	ADDRESS Gaithersburg Md

Spec.—8-24-14—M. & T.—2000 Bks.

D 8334 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D 8334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Hilkeland Ave St.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl William Fothergill

(Residence in Baltimore: No. 2864 Rayner Ave St.; no yrs., 6 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, ... February ..... 16 ..., 1917
(Month) (Day) (Year)

7-AGE, ... no yrs. 6 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Bennett Fothergill

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Edith C. H. Rees

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Chester Riland, M.D.

(Address).. 2532 Edmondson Ave.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... September ..... 9 ..., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 27 1917, to September 9 1917, that I saw him alive on September 4 1917, and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

..... Ileo-colitis .....

.....

.....

..... (Duration) no yrs. no mos. 18 ds.

CONTRIBUTORY..... none .....
(Secondary)

..... (Duration)..... yrs. — mos..... ds.

(Signed)... Chester Riland ....., M. D.

9-10-, 1917. (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Sept 12, 1917.

20-UNDERTAKER, John J. Fields — ADDRESS 200 N Gilmor

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8335

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2127 Maryland ave St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Gibson Carey

(Residence in Baltimore: No. 2127 Maryland ave St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, March 15th (Month) (Day), 1843 (Year)

7-AGE, 74 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 068
(a) Trade, profession, or particular kind of work..... Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Drug. House

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo. Carey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary E Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. L. Bartgis

(Address) 4 E. Madison St

15-

SEP 10 1917

ROBERT C. LEE

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1916, to Sept 9- 1917, that I saw h[illegible] alive on Sept 9 1917, and that death occurred, on the date stated above, at 10:05 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

OTH

(Duration) yrs. 2 3 mos. ds.

CONTRIBUTORY (Secondary) Anemia.

(Duration) yrs. 6 mos. ds.

(Signed) Meth-Liddell M. D.

Sept 10, 1917. (Address) 11 W Lexington Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 9/11/..., 1917

20-UNDERTAKER Henry W. Jenkins & Son — ADDRESS Mc. Culloh & Orchard Sts

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8836 — 30 — D 8836

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 612 N. Central Ave St.; 5 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Donnelly

(Residence in Baltimore: No. 612 N. Central ave St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
F	Colored	Married

6-DATE OF BIRTH — (Month) — (Day) , 1894 (Year)

7-AGE — 23 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework (037)
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE (State or country): Marion S. C.

PARENTS

10-NAME OF FATHER: Ezekiah Bird

11-BIRTHPLACE OF FATHER (State or country): Marion S. C.

12-MAIDEN NAME OF MOTHER: Julia Brightford

13-BIRTHPLACE OF MOTHER (State or country): Marion S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Donnelly

(Address) 612 N. Central ave

15- SEP 10 1917 — HARRY C. ANDREWS — Registrar of Vital Statistics

....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH — 9 (Month) 10 (Day) , 1916 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1917, to Sept 9 1917. that I saw h[illegible] alive on Sept 9, 1917. and that death occurred, on the date stated above, at 12:40 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tubercular)

(Duration) 5 weeks. yrs. mos. ds

Contributory (SECONDARY) .....

(Duration) yrs. mos. ds.

(Signed) A. L. Hornstein M. D.

9/10, 1917. (Address) 733 Argyle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Marion S. C. — DATE OF BURIAL: Sept 10th, 1917

20-UNDERTAKER: Chas G Bailey — ADDRESS: [illegible] Jefferson St

N. B.—Every item of information above is required by law. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Every item must be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 8337

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Stimpson (Stimpson)

(Residence in Baltimore: No. 1714 Wagner St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Apr. (Month) 18 (Day), 1912 (Year)

7-AGE, 5 yrs. 4 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Stimpson

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Lillian Vickers

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp.

15-

SEP 10 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept. 10 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis of femur

(Duration) 2 yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) — yrs. — mos. — ds.

(Signed) Emmett P. Smith M. D.

Sept 10, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State 5 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? 1714 Wagner St

Former or usual residence 1714 Wagner St

19-PLACE OF BURIAL OR REMOVAL, Balto Cem. DATE OF BURIAL. Sept. 13 1917.

20-UNDERTAKER Wm Cook. ADDRESS 502 E Nath ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 8338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Mosher ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Bromley

(Residence in Baltimore: No. 1410 Mosher St.; ....yrs. ....mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Sept 4th, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wilson Bromley

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Inglis Day

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H R Haddock M.D.

(Address) 117 N Carrollton

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Sept 7 1917, that I saw h.. alive on Sept 7 1917, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Abs't Umb Premature Labor

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H R Haddock M. D.

9/7, 191.. (Address) 117 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

important. See instructions on back of certificate.

SEP 10 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 8339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 8339

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Roadcap.

(Residence in Baltimore: No. Linden Ave & Madison St.; —yrs.,—mos. 3¼ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, Sept. (Month) 9 (Day), 1917 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 3 hrs. or 45 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 200

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Roadcap

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Stella Roadcap

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jr. J. Roberts M.D.

(Address) Md General Hospital

15-

Filed SEP 10 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 9 1917, to Sept 9 1917, that I saw her alive on Sept. 9 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

(a) Premature

(b)

(c)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) .....yrs.....mos.....ds.

(Signed) J. J. Roberts M. D.

9-10, 1917. (Address) Md Gen Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. 3¼ hrs. In the State.....yrs.....mos.....ds. 3¼ hrs.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS

Burial Permit Issued Commissioner Health.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 8340

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2735 N. Charles ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G. Mills

(Residence in Baltimore: No. 2735 N. Charles St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ...May.... (Month) ....22.... (Day), 1854. (Year)

7-AGE, ...63....yrs....3....mos....18....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Stove Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ezekiel Mills

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jerusha Kilbourn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rowland J. Mills

(Address) 2136 Mt. Holly St.

15-

SEP 10 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Sept.... (Month) ....9.... (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1917, to Sept 9 1917, that I saw h.. alive on Sept 9 1917, and that death occurred, on the date stated above, at 4.02 m.

The CAUSE OF DEATH* was as follows:

Carcinoma
Clinical & microscopical diagnosis
.....(Duration)....yrs. 3 mos....ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri
Total Hysterectomy
.....(Duration)....yrs. 6 mos....ds.

(Signed) Walter Hoffman M. D.

Sept 10, 1917. (Address) 230 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Green Mount Cemetery	Sept. 11, 1917.
20-UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

N. B.—Every item of information must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Md. Gen. Hosp. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jasper Ridgley

(Residence in Baltimore.- No. 844 Hampson St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Dec. 14, 1871. (Month) (Day) (Year)

7-AGE. 45 yrs. 8 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labourer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Robt. Ridgley

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ellen ?

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Ridley

(Address) 844 Hampson St

15-

Filed SEP 10 1917, 191.... MARY C. ANDREWS

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 8, 1917, that I saw him alive on Sept 8, 1917, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Strangulated ing. hernia

..... (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute cardiac dil.

..... (Duration) yrs. mos. ds.

(Signed) J. H. Lawson M. D.

Sept 8, 1917. (Address) Mt. Hope Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 2 mos. ds. In the State 25 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 844 Hampson St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	Sept 11, 1917.
20-UNDERTAKER James H. Dennis	ADDRESS 1303 Pennsylvania Ave

D 8342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital ST. 5 WARD) REGISTERED No. C 1981

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Magruder

(Residence in Baltimore: No. 211 N. High St. St.; Like mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) , 1 (Day) (Year)

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Rifler.
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John L. Magruder

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Smith.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gruen.

(Address) 727 Hallowy

15-

Filed ....., 191.... Registrar.

SEP 10 1917 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution Coming in Contact with Electric Current

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Driscoll M. D.
(Coroner)
Sept 10, 1917 (Address) 312 N Carrollton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Westport Electric House

Former or usual residence 211 N High St

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel DATE OF BURIAL, Sept 11, 1917

20-UNDERTAKER Ed Byrne ADDRESS 302 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D 8343

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8343

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 N. Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L Reeves

(Residence in Baltimore: No. 1326 N Washington St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) married

6-DATE OF BIRTH, Oct (Month) 21 (Day), 1851 (Year)

7-AGE, 65 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lab
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Queens Annis Co Md

PARENTS.

10-NAME OF FATHER, Robert L Reeves

11-BIRTHPLACE OF FATHER (State or Country) Queens Annis Co Md

12-MAIDEN NAME OF MOTHER Jane Wilkins

13-BIRTHPLACE OF MOTHER (State or Country) Queens Annis Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Reeves

(Address) 1326 N. Washington St

15-

SEP 10 1917

Filed....., 191.....

ROBERT C. ATKINS
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 9 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 1917, to Sept 1917, that I saw her alive on Sept 9 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Coma

(Duration) yrs. mos. 1 ds.

(Signed) W M Lee M. D.

9/10, 1917. (Address) 707 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL. Sept 11, 1917

20-UNDERTAKER W M Cook

ADDRESS 502 E North Ave

important. See instructions on back of certificate.

D 8314

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 8314

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 943 N. Franklin ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles L. Taylor

(Residence in Baltimore: No. 943 N. Franklin St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. 29, 1837 (Month) (Day) (Year)

7 AGE: 79 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer): 057

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Jesse Taylor

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Lafayette Taylor

(Address) 943 N. Franklin St

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 10, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1917, to Sept 10 1917.

that I saw h[illegible] alive on Sept 9, 1917.

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Senile Cerebro-Sclerosis,
Chronic Myocarditis
Hemiplegia

(Duration) yrs. About 2 mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Dr. Carroll Lockard M. D.

Sept 10, 1917. (Address) 46 Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ort O Cook — DATE OF BURIAL: Sept 12, 1917

20 UNDERTAKER: Geo W Little — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8345

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8345

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No 1403 N. Sutton Ave St.; 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie F. Peregoy

(Residence in Baltimore: No. 1403 N Sutton Ave St.; 28 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April (Month) 12 (Day), 1875 (Year)

7-AGE: 42 yrs. 4 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: John W Phillips

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Margaret Hoffman

13-BIRTHPLACE OF MOTHER (State or country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo A Peregoy

(Address) 1403 N Sutton Ave

15-

SEP 10 1917

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 9 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 1, 1917, to Sept. 9, 1917, that I saw h[illegible] alive on Sept 6, 1917, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Squamous Cell Carcinoma of Uterus

(Duration) 1 yrs. — mos. — ds

Contributory (SECONDARY) Metastases in Pelvic with Cachexia - Exhaustion

(Duration) — yrs. — mos. — ds.

(Signed) Howard Jacobs M. D.

Sept 10, 1917 (Address) Marlborough Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 11, 1917

20-UNDERTAKER: Geo W Little — ADDRESS: 1731 Fremont Ave

N. B.-Every item of information should be carefully supplied. AGE should be given EXACTLY in every case. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8346

CERTIFICATE OF DEATH.

REGISTERED No. C 174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1462 Reynolds St. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcelin Sosnowski.

(Residence in Baltimore: No. 1462 Reynolds St. St.; 27. yrs., mos. ds.)

Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White.	Married.

6-DATE OF BIRTH. November 1st. 1862., /
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
54 yrs. 10 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman of 086
(b) General nature of industry, business, or establishment in which employed (or employer): Stevedores.

9-BIRTHPLACE, (State or Country): Russia.

PARENTS.

10-NAME OF FATHER: Clements Sosnowski.

11-BIRTHPLACE OF FATHER (State or Country): Russia.

12-MAIDEN NAME OF MOTHER: Eva Anelia.

13-BIRTHPLACE OF MOTHER (State or Country): Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sosnowski.(son)

(Address) 1462 Reynolds St.

15-

SEP 10 1917

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry
(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage, having been struck in the back by a block and fall. Accidental death.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Sept. 10, 1917. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cem. A.A. county	9/11, 1917
20-UNDERTAKER	ADDRESS
J. Fus McCully	130 E. Fort Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 8347

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Burrs

(Residence in Baltimore: No. 1015 N Chapel St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	colored	married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1865 (Year)

7-AGE. 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 437

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo Boarding

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Murrina Coots

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriett Barnes

(Address) 1015 N Chapel St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 8 1917, that I saw her alive on Sept 8 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

4 days (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Edward Foster M. D.

Sept 9, 1917 (Address) 1612 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	Sept 11th, 1917.
20-UNDERTAKER Joseph A Farrell	ADDRESS 2319 Division

important. See instructions on back of certificate.

D 8313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8313

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 630 Bradley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mclean Mrs E

(Residence in Baltimore: No. 630 Bradley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1876 (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 840

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Mclean

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Mclean

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brother

(Address) 630 Bradley

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Ulcer

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Sept. 10, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ft Auburn Cemetery — DATE OF BURIAL, Sept 11, 1917.

20-UNDERTAKER Geo H Harper — ADDRESS 607 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8319 D 8319

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3021 O'Donnel St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Penn

(Residence in Baltimore: No. 3021 O'Donnel St. St.: ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May 31, 1911
(Month) (Day) (Year)

7-AGE, 6 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Penn

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elizabeth Schor

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Penn

(Address) 3021 O'Donnel St

15-

Filed....., 191.....
Registrar.

SEP 11 1917 HARRY C. ANDREWS

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1917, to Sep 10 1917, that I saw h[e] alive on Sep 10 1917, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Faucial Diphtheria

(Duration) ...yrs. ...mos. 16 ds.

CONTRIBUTORY (Secondary) Paralysis of heart

(Duration) ...yrs. ...mos. 6 hrs.

(Signed) Leon Marbourg M. D.

Sep 10, 1917. (Address) 3031 O'Donnel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem.	Sept. 11, 1917.
20-UNDERTAKER Zirkle & Zirkle	ADDRESS 1739 E. Eager

Spec.—8-24-14—M. & T.—2000 Blks.

D 8350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8350

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert St. ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harvey Hook

(Residence in Baltimore: No. Burkittsville Md St.; yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Unknown (Month), 1 (Day), ... (Year)

7-AGE.	If LESS than 1 day,
57 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Book
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country), Frederick Co Md.

PARENTS.

10-NAME OF FATHER, Henry Hook

11-BIRTHPLACE OF FATHER (State or Country). Frederick Md.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Frederick Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Florence Hook

(Address) Burkittsville Md

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Sept 11 1917, that I saw h[im] alive on Sept 10 1917, and that death occurred, on the date stated above, at 2.30 Am.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

..... (Duration) Dont Know

CONTRIBUTORY (Secondary) Nephritis Chronic

..... (Duration) Dont Know

(Signed) Edward B Smith M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Brunswick Md.	Sept 12th, 191.

20-UNDERTAKER	ADDRESS
John Howard Low.	907 Hollins St.

DEC 11 1917 HARRY O. ANDREWS

Spec.—8-24-14—M. & T.—2000 Bks.

D 8351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8351

CERTIFICATE OF DEATH.

REGISTERED NO. C 1044

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Fleet ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Nowak.

(Residence in Baltimore: No. 1906 Fleet. St.; 1 yrs., 1 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 5, 1916.
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Stanislaus Nowak.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore. Md.

12-MAIDEN NAME OF MOTHER Mary Szemborski.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Nowak.

(Address) 1906 Fleet St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 6 1917, to Sept 10 1917, that I saw h.. (alive on Sept 10 1917, and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pleuro-Colitis.

(Duration) 4 days 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. Jansen Jr. M. D.

Sept 10, 1917. (Address) 2431 Fait Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, SEP. 11, 1917

20-UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8352 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8352

+104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Eydelloth

(Residence in Baltimore: No. 4514 Eastern Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. March 24, 1917. (Month) (Day) (Year)

7-AGE. ....yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Eydelloth

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Katherine Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J. Baumberger

(Address) Johns Hopkins Hosp.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1917, to Sept. 8, 1917, that I saw h.. alive on Sept. 8 1917, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

Acute

(Duration) ....yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) None (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Conrad M. D.

Sept. 8, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 2 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4514 Eastern Avenue

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Sept. 11th, 1917.

20-UNDERTAKER Lilly & Son ADDRESS 403 E. Monument.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8353 50 ✓ D 8353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. Presbyterian Eye Ear Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Neff.

(Residence in Baltimore: No. 1 N. Streeper. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, November 5, 1853 (Month) (Day) (Year)

7-AGE, 63 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 13

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Neff.

(Address) 1 N. Streeper St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 5th 1917 to Sept 8 1917, that I saw her alive on Sept 8 1917, and that death occurred, on the date stated above, at 0 4 m.

The CAUSE OF DEATH* was as follows:

Epidural Abscess following
Fracture of Cranium
Presbyterian Eye Ear Hospital Sept 7 1917
(Chronic) Nephritis (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

Several years (Duration) yrs. mos. ds.

(Signed) A. F. Hardy M. D.

Sept 8, 1917. (Address) 1902 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1 N Streeper St

Former or usual residence 1 N Streeper St

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Sept 12th, 1917.

20-UNDERTAKER, Lilly & Feiler. ADDRESS 1035 N Gilmor

Check all items carefully. Items marked with † are important. See instructions on back of certificate.

D 8351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 8351

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Johns Hopkins, Hospital ST.: WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Rose

(Residence in Baltimore: No. 2820 Fulton St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, May 29, 1916
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
1 yrs. 3 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Rose

11-BIRTHPLACE OF FATHER. (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ella McCord

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Rose
(Address) 2820 Fulton St.

15-
Filed....., 191.....
HARRY C. ANDREWS
SEP 11 1917
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobular
Left Lung
Days (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. K. Bowie (Coroner.) M. D.
Aug 11, 1917 (Address) 611 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos. 2 ds. In the State. 3 yrs. 11 mos. ds.
Where was disease contracted, if not at place of death? 2826 Fulton St
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Aug 12, 1917

20-UNDERTAKER	ADDRESS
Stephen Tuckahoe	1011 E. Fenwick

N.B. Every certificate must be filled out in full, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8355 D 8355 151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 W. Lombard. St.; 16 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Annie Sakwiews

(Residence in Baltimore: No. 815 W. Lombard St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem'l

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Sing'l

6-DATE OF BIRTH. Aug. (Month) 1 (Day), 1917 (Year)

7-AGE. ....yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Joseph Sakwiews

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Anna Nows.

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Sakwiews

(Address) 815 W. Lombard St

15-

Filed....., 191.....

Registrar.

SEP 11 1917 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 10 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 191 , to Sept 11 191 , that I saw h[er] alive on Sept 11 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Dr. J. H. Doane M. D.

....., 191.. (Address) 820 Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Stanislaus — DATE OF BURIAL. Sept. 10., 191.

20-UNDERTAKER John Zebliauskas — ADDRESS 425 S Paca St

See instructions on back of certificate. Important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8356 41 D 8356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 S. Robinson St. 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry St. Heath

(Residence in Baltimore: No. 922 S. Robinson St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, whit

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.) Marr'd

6-DATE OF BIRTH, Dec 2, 1877
(Month) (Day) (Year)

7-AGE, 39 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

655

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER. Henry Heath

11-BIRTHPLACE OF FATHER (State or Country), Washington DC

12-MAIDEN NAME OF MOTHER Caroline Smith

13-BIRTHPLACE OF MOTHER (State or Country), Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Heath

(Address) 922 S. Robinson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 191 7, to Sept 9 191 7, that I saw h.. alive on Sept 8 191 7, and that death occurred, on the date stated above, at 5.15a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. ds.

(Signed) Wm. J. Peddicord M. D.

Sept 9, 191 7 (Address) 801 N. Keyser

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, H of J Redeemer Cem. | DATE OF BURIAL, Sept 12, 1917

20-UNDERTAKER Jno A. Duran | ADDRESS 300 E Baltimore St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8357

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732 S Luzerne Ave. (St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Helen Auld

(Residence in Baltimore: No. 732 S Luzerne Ave. St.; ..... yrs., 3 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 14 (Day), 1914 (Year)

7-AGE, ... yrs. 3 mos. 25 ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Auld

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Rachuta

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Auld

(Address) 732 S Luzerne Ave

15- SEP 11 1917 HARRY C. ANDERS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 10 1917, that I saw her alive on Sept 10 1917, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

..... Acute Hep Colitis

..... (Duration) ..... yrs. ca 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Sept 10, 1917 (Address) 2431 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem	Sept 12, 1917
20-UNDERTAKER	ADDRESS
Stephen Kaikaski	1009 Fleet Ave

CAUSE OF DEATH must be plainly written. All questions must be answered if important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8358

CERTIFICATE OF DEATH.

64 D 8358

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 n Mount ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary a Collins

(Residence in Baltimore: No. 723 n Mount St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ~~Feb~~ (Month) 25 (Day) 1840 (Year)

7-AGE, 77 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Brens

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Cathrain Henry

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Kate Collins

(Address) 720 N Mount St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 9 1917, that I saw her alive on Sept 9 1917, and that death occurred, on the date stated above, at 10.45 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) —yrs. —mos. —ds.

(Signed) Wm P Lucas M. D.

Sept 10, 1917. (Address) 1 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Sept 12, 1917

20-UNDERTAKER John J Kelly — ADDRESS 1508 W Lombard

Cross out words not important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8359

CERTIFICATE OF DEATH.

28 ✓ D 8359

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 355 Fort Hill Av St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H Schilling

(Residence in Baltimore: No. 355 Fort Hill Ave St.; 31 yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 17th, 1886
(Month) (Day) (Year)

7-AGE, 31 yrs. mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

480

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas R. Schilling

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hattie Singer

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret E. Schilling

(Address) 355 Fort Hill Ave

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1917, to Sept 8 1917, that I saw h[illegible] alive on Sept 8 1917, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W Jones M. D.

Sept 10, 1917. (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Sept. 11, 1917.

20-UNDERTAKER E. B. Hufnagel

ADDRESS 2758 Frederick Ave

CAUSES OF DEATH should be stated by the physician in plain English terms. Indefinite and unsatisfactory terms, such as "Debility," "Old Age," "Exhaustion," "Heart Failure," "Convulsions," "Fever," "Cancer," "Consumption," "Tumor," "Abscess," "Child-bed," "Paralysis," "Jaundice," "Dropsy," "Childbirth," "Premature Birth," "Stillborn," "Infantile," "Malformation," "Senility," "Lockjaw," "Blood Poisoning," "Inflammation," "Hemorrhage," "Ulceration," "Suppression," "Fever," "Gastritis," "Enteritis," "Colitis," "Meningitis," "Pneumonia," "Bronchitis," "Pleurisy," "Nephritis," "Kidney Disease," "Bright's Disease," "Diabetes," "Hepatitis," "Cirrhosis," "Peritonitis," "Appendicitis," "Rheumatism," "Anemia," "Marasmus," "Uremia," "Septicemia," "Pyemia," "Gangrene," "Carcinoma," "Sarcoma," "Tuberculosis," "Typhoid," "Malaria," "Scarlet Fever," "Measles," "Whooping Cough," "Diphtheria," "Erysipelas," "Smallpox," "Cholera," "Yellow Fever," "Plague," "Leprosy," "Rabies," "Glanders," "Anthrax," "Tetanus," "Hydrophobia," "Influenza," "Grippe," "Mumps," "Chickenpox," "Rubella," "Rubeola," "Scarlatina," "Varicella," "Variola," "Vaccinia," "Typhus," "Typhoid," "Malaria," "Scarlet Fever," "Measles," "Whooping Cough," "Diphtheria," "Erysipelas," "Smallpox," "Cholera," "Yellow Fever," "Plague," "Leprosy," "Rabies," "Glanders," "Anthrax," "Tetanus," "Hydrophobia," "Influenza," "Grippe," "Mumps," "Chickenpox," "Rubella," "Rubeola," "Scarlatina," "Varicella," "Variola," "Vaccinia," "Typhus," are important. See instructions on back of certificate.

SEP 11 1917 [illegible] Registrar

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Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8360

CERTIFICATE OF DEATH.

28 ✓ D 8360

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2641 Frederick Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward P Sauerwald

(Residence in Baltimore: No. 2641 Frederick Av St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. January 11th, 1873 (Month) (Day) (Year)

7-AGE, 44 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer). merchant

9-BIRTHPLACE, (State or Country) Baltimore-Md

PARENTS.

10-NAME OF FATHER. Fred'k Sauerwald

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Quinn

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Sauerwald

(Address) 2641 Fred'k Av

15-

Filed ....., 191.... Registrar.

SEP 1 1917 ROBERT C. ARMSTRONG Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4 1915, to Sept 1 1917, that I saw h.. alive on Sept 2 1917, and that death occurred, on the date stated above, at 5. A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard W Lee M. D.

Sept 10, 1917. (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL. Sept 3 1917

20-UNDERTAKER. F. B. Wisiport

ADDRESS 1731 Pleasant Av

CAUSE OF DEATH must be stated in such terms as will indicate the disease, and not the mode of dying. Indefinite terms, such as "Paralysis," "Exhaustion," "Heart Failure," "Old Age," "Dropsy," "Cancer," "Tumor," "Fever," "Abscess," "Child-bed," "Accident," "Injury," "Fracture," "Drowning," are not sufficient. Deaths from violence must state the MEANS and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Deaths from Puerperal State must state the number of days between delivery and death. Deaths from Cancer must state the location and duration. Deaths from Tuberculosis must state the organ affected. Deaths from Fever must state the number of days' illness. Deaths from Old Age must state the principal diseases and contributory causes, if any. Deaths of Infants must state whether Premature Birth, Congenital Debility, Malformation, or Injury at Birth. Deaths of Children must state whether Scarlet Fever, Measles, Whooping Cough, Croup, Diphtheria, Cholera Infantum, Meningitis, Convulsions, Teething, or Marasmus. Deaths from Contagious Diseases must state whether Vaccinated, and if so, when. Deaths from Consumption must state whether Pulmonary or Laccinated, and if so, when. Deaths from Consumption must state whether Pulmonary or Laryngeal. Deaths from Diarrhoea must state whether Chronic or Acute. Deaths from Dysentery must state whether Chronic or Acute. Deaths from Erysipelas must state whether Chronic or Acute. Deaths from Inflammation must state whether Chronic or Acute. Deaths from Ulceration must state whether Chronic or Acute. Deaths from Hemorrhage must state whether Chronic or Acute. Deaths from Jaundice must state whether Chronic or Acute. Deaths from Paralysis must state whether Chronic or Acute. Deaths from Rheumatism must state whether Chronic or Acute. Deaths from Rupture must state whether Chronic or Acute. Deaths from Tetanus must state whether Chronic or Acute. Deaths from Tumor must state whether Chronic or Acute. Deaths from Ulceration must state whether Chronic or Acute. Deaths from Whooping Cough must state whether Chronic or Acute. Deaths from Worms must state whether Chronic or Acute. Deaths from Yellow Fever must state whether Chronic or Acute. Deaths from Zymotic Diseases must state whether Chronic or Acute.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8361 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 104 D 8361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clement Heilker

(Residence in Baltimore: No. 934 E. Eager St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 11, 1917
(Month) (Day) (Year)

7-AGE, 0 yrs. 7 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clement Heilker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ireke Walter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J. Rosenberg

(Address) Johns Hopkins Hosp

15- KARL C. ANDREWS SEP 11 1917

Filed....., 191.....

Registrar.

CAUSE OF DEATH must be plainly written and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 1917, to Sept 11 1917, that I saw h.. alive on Sept 11 1917, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

Acute

About 3 weeks
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Conrad M. D.

Sept 11 1917. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 7 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence 934 E. Eager St

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Sept 12, 1917.

20-UNDERTAKER Henry Horst Sons

ADDRESS 931 E. Eager St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8362 104 D 8362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Richmond

(Residence in Baltimore: No. 1020 Watson St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Child

6-DATE OF BIRTH. March 11, 19[illegible]
(Month) (Day) (Year)

7-AGE. yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Cecil. Md

PARENTS.

10-NAME OF FATHER. Leo Richmond

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Lena Sugerman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Biddle

15-

Filed ....., 191.....
Registrar.

CAUSE OF DEATH. This line must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 3 191 , to Sept. 11 1917, that I saw h[illegible] alive on Sept. 11 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Dysentery - Neurasthenia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Pyelo-Nephritis

(Duration) yrs. mos. ds.

(Signed) Bernard Sachar M. D.

Sept. 11, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1020 Watson St.

Former or usual residence 1020 Watson St.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Mt. Carmel | DATE OF BURIAL. Sept. 13, 1917

20-UNDERTAKER Jack Lewis 1411 E. Biddle | ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D 8363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D 8363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Peach Alley WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Johnson

(Residence in Baltimore: No. 813 Peach Alley (If not in Baltimore give usual residence.) (Age: 0 yrs., 11 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, September 26, 1916 (Month) (Day) (Year)

7-AGE, 0 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant. 800
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Gleavitz Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md., Maryland.

12-MAIDEN NAME OF MOTHER Laura Janey.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Laura Johnson

(Address)... 813 Peach Al.

15-

SEP 11 1917

Filed....., 191.....

Registrar.

CAUSE OF DEATH must be filled in plain terms, so that it can be understood. Do not use abbreviations or technical terms. Be particular and definite. Do not say "Fever," "Inflammation," "Cancer," "Consumption," "Dropsy," "Old Age," "Debility," "Convulsions," "Hemorrhage," "Accident," "Fracture," "Drowning," or "Homicide," without stating the cause which produced these conditions. If the deceased was a woman, whether single, married, or widow, and if death occurred during pregnancy, or within one month after delivery, or during labor, state the fact. If deceased was an infant, state whether it was born alive, and how long it lived. In all cases where there was a doctor in attendance, he must sign the certificate, and must state the time he last saw the deceased alive. In all cases of violent death, the coroner must hold an inquest, and must sign the certificate. In all cases of death from violence, or suddenly when apparently in health, or when the body is found dead, or when the cause of death is unknown, the coroner must hold an inquest, and must sign the certificate. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September, 10, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1917, to Sept. 10, 1917, that I saw her alive on Sept. 10, 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute

Bronchopneumonia

(Duration)...yrs...mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration)...yrs...mos...ds.

(Signed) David Trauschild M. D.

9/11, 1917 (Address) 172 W. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Sept. 12, 1917
20-UNDERTAKER	ADDRESS
J. L. Brauschild Son	108 N. Monroe

Spec.—8-24-14—M. & T.—2000 Blks.

D 8361 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8361

8 92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 Hillsmont St.; 24 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Female Johnson

(Residence in Baltimore: No. 1042 Hillsmont St.; yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 4, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Percy Johnson

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER Katie Unger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Johnson

(Address) 1042 Hillsmont St.

15-

Filed SEP 11 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 9 1917, that I saw him alive on Sept 9 1917, and that death occurred, on the date stated above, at 7 45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Primary (Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) Heart disease

(Duration) ....yrs. 1 mos. 7 ds.

(Signed) Henry B Roth M. D.

M., Sept 10, 1917. (Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, Sept 11, 1917

20-UNDERTAKER J J Fahey & Sons — ADDRESS

CAUSE OF DEATH must be plainly written, and all questions answered so far as possible. Every item important. See instructions on back of certificate.

Spec.—6-24-14—M. & T.—2000 Bks.

D 8365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8365

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Faidley

(Residence in Baltimore: No. 603 S. St. Sparrows Point St. — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, December 11, 1916.
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 30 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Faidley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mattie Dickert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Feury D. Lausenberg

(Address) Johns Hopkins Hosp

15-[illegible]

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 4 1917, to September 10 1917, that I saw h[illegible] alive on September 10 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion, acute.

Canal Intubation

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry B. Conrad M. D.

Sept 10, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 6 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 603 S. St. Sparrows Pt.

19-PLACE OF BURIAL OR REMOVAL, Ashley Cemetery

DATE OF BURIAL, Sept 12 191.7

20-UNDERTAKER Sam. W. Chase - son

ADDRESS 1400, Mosher

CAUSE OF DEATH to be plain terms, important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8366

CERTIFICATE OF DEATH.

108 D 8366

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N Eutaw ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Mary M Fisher

(Residence in Baltimore: No. 314 N Eutaw St.; ~ yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 22, 1837 (Month) (Day) (Year)

7-AGE, 80 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wilcox

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Walker

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Cobourn Hudgins

(Address) 314 N. Eutaw St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Sept 11 1917, that I saw h[illegible] alive on Sept 11 1917, and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Obstruction

(Duration) 4 days

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. 6 mos. 1 ds.

(Signed) Chas. C. Hudgins M. D.

Sept 11, 1917. (Address) 314 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 8 mos. - ds. In the State 1 yrs. 8 mos. ds.

Where was disease contracted, if not at place of death? 314 N. Eutaw St.

Former or usual residence 314 N. Eutaw St.

19-PLACE OF BURIAL OR REMOVAL, Uniontown Pa. DATE OF BURIAL, Sept 13, 1917

20-UNDERTAKER H. J. Hummer Son ADDRESS Norma

CAUSE OF DEATH must be plainly written. All questions should be answered. Information important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8367

D 8367

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 S. Bethel ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josef Jahunski

(Residence in Baltimore: No. 526 S. Bethel St.; ..... yrs., 9 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, June 6, 1912
(Month) (Day) (Year)

7-AGE, ... yrs. 9 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Benjamin Jahunski

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland

12-MAIDEN NAME OF MOTHER Anna Jakas

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Jachunski

(Address) 526 S. Bethel St.

15-

Filed ....., 191....

Registrar.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Sept 11 1917, that I saw h[illegible] alive on Sept 10 1917 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Entero Colitis,

.....

..... (Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) [signature] M. D.

Sept 11, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept 11, 191...

20-UNDERTAKER William Fralzowski — ADDRESS 1115 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8368 ✓ D 8368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+1

8

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. St. Joseph's Hospital ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Dilmuth

(Residence in Baltimore: No. Towson Md. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 21 (Day), 1893 (Year)

7-AGE, 24 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Theodore Riley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Dilmuth

(Address) Towson Md.

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Sept 7 1917, that I saw h e r alive on Sept 7 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Fatty Degeneration of Heart (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Merkel M. D.

....., 191... (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Towson Md

Former or usual residence Towson Md

19-PLACE OF BURIAL OR REMOVAL, St. Josephs Cemetery

DATE OF BURIAL, Sept. 12, 1917

20-UNDERTAKER Fred Lassahn & Sons

ADDRESS Fullerton Md.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8369

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 W. Fayette ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. McHenry

(Residence in Baltimore: No. 1633 W. Fayette St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 7 (Day), 1868 (Year)

7-AGE, 49 yrs. 2 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Michael J. McHenry

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Wallace

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. McHenry

(Address) 1633 W. Fayette St

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, as that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Feb 10 1917, that I saw h.. alive on Feb 9 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tonicclonic Convulsions

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) E. L. Cantelmo M. D.

Feb 10, 191... (Address) 24 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem.

DATE OF BURIAL, Feb. 12, 1917

20-UNDERTAKER M. L. Flynn

ADDRESS 1422 Light

Spec.—5-19-13—M. & T.—500 Bks.

B 8370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 ✓ B 8370

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1624 St Charles ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan T. Saunders,
(Residence in Baltimore: No. 1624 St Charles St.: 74 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Jan (Month) 11 (Day), 1843 (Year)

7-AGE, 74 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel H. Laurence

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan Turner

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ina Laurence
(Address) 1624 St Charles St

15-
Filed SEP 11 1917, 191.... Registrar.

CAUSE OF DEATH to be filled in, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 10 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1917, to Sept 10 1917, that I saw her alive on Sept 9 1917, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:
Hypertrophied Heart
(Duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Cancer of intestines
(Duration) yrs. 3 mos. ds.

(Signed) D. F. Hawkins M. D.
Sept 11 1917 (Address) 6 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London PK Cem	9/12, 1917
20-UNDERTAKER	ADDRESS
D. Fun m: Co. Cy	130 E. Fort Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8371

CERTIFICATE OF DEATH.

8 D 8371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Vine ST.: 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertie Beard

(Residence in Baltimore: No. 1519 Vine St. St.: 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Child

6-DATE OF BIRTH, Sept. (Month) 17 (Day), 1914 (Year)

7-AGE, 3 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... —
(b) General nature of Industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Baltimore City Md.

PARENTS.

10-NAME OF FATHER, Robert Beard

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Coleman

13-BIRTHPLACE OF MOTHER (State or Country), Annearundel Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Beard

(Address) 1519 Vine St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5- 1917, to Sept. 10- 1917, that I saw her alive on Sept. 10- 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. McCarthy M. D.

Sept. 10 191 7 (Address) 4062 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Sept. 11 191 7

20-UNDERTAKER Wilbur Brown.

ADDRESS 1142 N. Schroeder St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Care in filling of important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8372

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospital ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Fyler

(Residence in Baltimore: No. 886 Rabory St.; 5 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Black	single

6-DATE OF BIRTH, Apr. (Month) 3 (Day), 1887. (Year)

7-AGE, 33 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, James Fyler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Frances Fyler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Frances Fyler

(Address) 886 Rabory st.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-3 1917, to 9-10 1917, that I saw him alive on 9-10 1917, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial disease

(Duration) unknown yrs. mos. ds.

(Signed) B. B. Brumbaugh M. D.

Sept. 10 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 7 ds. In the State ... yrs. life mos. ... ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 886 Rabory St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept. 12 1917.

20-UNDERTAKER Brown & Freeland — ADDRESS 1140 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation important. See instructions on back of certificate.

SEP 11 1917 ROBERT R. KRAUTH

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8373

CERTIFICATE OF DEATH.

REGISTERED NO. C 52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Little

(Residence in Baltimore: No. 421 N. High St. St.: ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE.	If LESS than 1 day,
18 yrs. ... mos. ... ds.	...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Little

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Hunter

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Coroner's Office

(Address) Court St.

15-

Filed ....., 191...

Registrar.

SEP 11 1917 ROBERT B. KRAUT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 191..., to Sept 9, 191..., that I saw him alive on Sept 9, 191..., and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease

Contusion

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Edward O. Smith M. D.

Sept 9, 191... (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? 421 N. High St.

Former or usual residence 421 N. High St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet	Sept 12, 191...
20-UNDERTAKER	ADDRESS
Wm. Baker & Son	318 Lee St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8374

CERTIFICATE OF DEATH.

79 D 8374

1-PLACE OF DEATH (a) REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Church Home & Inf. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Erichsbergh

(Residence in Baltimore: No. Church Home & Inf. St.; 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
White	Female	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1842 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Cecil County, Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Church Home & Infirmary

(Address) Eastaway & Fairmount Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Sept 11 1917, that I saw her alive on Eleventh Sept 1917, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Arteriosclerosis
Hypertension

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 10 mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Mary's City Md	Sept 17, 191...
20-UNDERTAKER H E Hughes	ADDRESS 21 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 21 1917 ROBERT P. KRAUTHER Burial Permit Agent

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8375

CERTIFICATE OF DEATH.

X 42 D 8375

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Riley (Mrs)

(Residence ~~in Baltimore: No.~~ Charlestown W. Va. St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, July (Month) 12th (Day) 1855 (Year)

7-AGE, 62 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). W. Va.

PARENTS.

10-NAME OF FATHER, Joseph Crain

11-BIRTHPLACE OF FATHER (State or Country). W. Va.

12-MAIDEN NAME OF MOTHER Margaret Isler

13-BIRTHPLACE OF MOTHER (State or Country). W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Keen, M D

(Address) Union Prot Infirmary

15- Filed Sept 11, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1917, to Sept 11th 1917, that I saw her alive on Sept 11th 1917, and that death occurred, on the date stated above, at 10 03 m.

The CAUSE OF DEATH* was as follows:

Pelvic Carcinosis

Operation Sept 8th 17

Cancer of Uterus (Duration)....yrs....mos.....ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration)....yrs....mos.....ds.

(Signed) G. B. Micklethwaite M. D.

Sept. 11, 1917. (Address) M. P. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Charlestown W. Va.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Charles Town W. Va	Sept. 12. 1917
20-UNDERTAKER	ADDRESS
John E. Mitchell	1201 N. Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8376 ✓ 1X 156 D 8376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 519 W Melbourne St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Brennan

(Residence in Baltimore: No. Washington D.C. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 19, 1889
(Month) (Day) (Year)

7-AGE, 28 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer): 163

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Patrick Brennan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary A. Murray

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle Brennan

(Address) Washington D.C.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas- Poison. (Suicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. D. Brunelle M. D.
(Coroner)
Sept 12, 191.. (Address) 512 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Washington D.C.	Sept 12, 1917

20-UNDERTAKER	ADDRESS
H. W. Mears & Son	805 N. Calvert St.

N.B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8377 — 104 — D 8377

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Elliott St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa C Muhlberger

(Residence in Baltimore: No. 3120 Elliott St. St.; Life yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Jan. (Month) 23 (Day), 1917 (Year)

7-AGE, — yrs. 7 mos. 18 ds. — If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Peter J. Muhlberger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louisa Hertz

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Muhlberger

(Address) 3120 Elliott St.

15-

Filed ....., 191.... Registrar.

SEP 12 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 29th 1917, to Sept 11th 1917, that I saw her alive on Sept 10th 1917, and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Lloyd W. Jones M. D.

Sept 11th, 191... (Address) 1010 E. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Carmel Cem. — DATE OF BURIAL, Sept. 13, 1917

20-UNDERTAKER Ginkler + Ginkler — ADDRESS 1739 E. Eager

81 D 8378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 511 N. Paris St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Lewis

(Residence in Baltimore: No. 511 N. Paris St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Sept. (Month) ..... (Day) 1887 (Year)

7-AGE: 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE (State or Country): Va

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Lewis

(Address) 511 N. Paris St.

15- SEP 12 1917 MARY C. ANDREWS

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured Ulcer Duodenum

Acute Dilatation Stomach

Dead Immediately

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nil

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Wade Williams M. D.

(Coroner)

Sept. 12, 1917. (Address) 911 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Richmond, Va. DATE OF BURIAL, Sept 12, 1917

20-UNDERTAKER Kelly & Rye ADDRESS 1610 Eutaw

N. B.—Every item of information should be carefully supplied. Age in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 875 So. Paca ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Virginia Grube

(Residence in Baltimore: No. 875 So. Paca St.; 1 yrs., — mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. 4, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. — mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS:

10-NAME OF FATHER, Joseph Grube

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Edith Kinsey

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Jos. Grube

(Address) 875 So. Paca St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 10 1917, that I saw her alive on Sept 10 1917, and that death occurred, on the date stated above, at 10-25 p. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Morley Stone M. D.

Sept 11 1917. (Address) Fleg. Columbia Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem. | DATE OF BURIAL, Sept 12 1917

20-UNDERTAKER Joseph L. Cook | ADDRESS 1003 Watts St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15-4 ✓ D 8380

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 618 Edmondson Av St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Rebecca Krantz

(Residence in Baltimore: No.) 618 Edmondson Av St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb 22, 1848 (Month) (Day) (Year)

7-AGE, 69 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, Wm P. Martin

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co Md.

12-MAIDEN NAME OF MOTHER Elizabeth Frantz

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Mrs D C Molley

(Address) 618 Edmondson Ave

15- Filed SEP 12 1917, 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1911 191, to Sept 11 th 1917, that I saw her alive on Sept 10 th 1917 and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. 9 mos. 6 ds.

(Signed) Marshall G Smith M. D.

Sept 11, 1917 (Address) 1 E 11 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Glenmount Cem DATE OF BURIAL, Sept 13, 191..

20-UNDERTAKER Joseph B Cook ADDRESS 1003 N Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8381

CERTIFICATE OF DEATH.

64 ✓ D 8381

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Cleveland ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella. M. Shaw

(Residence in Baltimore: No. 1130 Cleveland St.; 31 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Feb 16 (Month) (Day), 1856 (Year)

7-AGE, 61 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John C. Mangum

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary E. Harvey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Muhly

(Address) 1130 Cleveland St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 11 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 3 35 A. m.

The CAUSE OF DEATH* was as follows:

A paralytic

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Morley Shaw M. D.

Sept 11, 1917. (Address) 712 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Sept. 14, 1917

20-UNDERTAKER Mrs A Rohde Son — ADDRESS 730 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8382

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1426 N. Mount ST.: 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen Young

(Residence in Baltimore: No. 1426 N. Mount St.; yrs., 3 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Male	Col'd	Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1917 (Year)

7-AGE, ... yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

880

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Charles Young

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Lizzie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1426 N Mount

15-

SEP 12 1917

Filed ....., 191..

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the body (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept 13, 1917

20-UNDERTAKER	ADDRESS
Edward Ringgold	1403 2 Carey

Spec.—8-24-14—M. & T.—2000 Bks.

D 8383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8383

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 560 Mosher ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L Douglas

(Residence in Baltimore: No. 560 Mosher St. Lifers yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	Colored	Widow

6-DATE OF BIRTH, Unknown (Month) (Day) 1854 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, George H Douglas

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary L Jones

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Joyce

(Address) 560 Mosher st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Sept 8 1917, that I saw h[illegible] alive on Sept 5 1917, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Contracted) Tuberculosis of Pleura

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 8, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept 12 1917
20-UNDERTAKER	**ADDRESS**
Edward Ringgold	1463 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Dallas ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian M. Waldhauser

(Residence in Baltimore: No. 111 N. Dallas St.; Lifes yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 13 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
yrs. 3 mos. 28 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Waldhauser

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Marie Bell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Waldhauser

(Address) 111 N. Dallas st

15-

Filed....., 191.....

Registrar.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 10 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Sept 10 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Cystitis Colitis, Bronchitis

Marasmus

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Birth condition

(Duration) yrs. mos. ds.

(Signed) Howard C. Silver M. D.

Sept 10, 1917. (Address) 1914 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery DATE OF BURIAL. Sept 12 1917

20-UNDERTAKER. Christian Miller ADDRESS 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 8385

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 So. Lakewood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lavina Weatherbee

(Residence in Baltimore: No. 723 S. Lakewood Ave. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct. (Month) ..... (Day), 1848 (Year)

7-AGE, 68 yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Francis Oliver

11-BIRTHPLACE OF FATHER (State or Country) France

12-MAIDEN NAME OF MOTHER Annie Everett

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie R. Dilley

(Address) 915 S. Linwood Ave.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 1917, to Sept. 9 1917, that I saw h[illegible] alive on Sept. 9 1917, and that death occurred, on the date stated above, at 10:35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) [illegible] yrs. [illegible] mos. ..... ds.

(Signed) Annie R. Dilley M. D.

Sept. 10, 1917. (Address) 208 N. Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery — DATE OF BURIAL, Sept 12 1917

20-UNDERTAKER Christian Miller — ADDRESS 2534 Jefferson St

N. B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—5-19-15—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8386 64 ✓ D 8386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N. Calhoun St.; 14 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susannah Payer

(Residence in Baltimore: No. 524 N. Calhoun St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED, ~~or DIVORCED~~. (*Write* the word.) Widowed.

6-DATE OF BIRTH, March (Month) ..., 1832 (Day) (Year)

7-AGE, 85 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer). 000 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Wm H. Bazzoud

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Catherine Anderson

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara B. McElderry

(Address) 527 N. Calhoun St.

15-

Filed ..... 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5 1917, to Sept 10 1917, that I saw her alive on Sept. 10 1917, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriae Sclerosis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

(Signed) L. M. Harrison M. D.

Sept. 12, 1917. (Address) 1236 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cem. DATE OF BURIAL, Sept 13 191.7

20-UNDERTAKER John O. Whitehill ADDRESS 1201 W. Fayette St.

N. B.—Every item of information under the heads of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 ✓ D 8387

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 N Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Young

(Residence in Baltimore: No. 1036 N Calhoun St.; 18 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 47 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va "

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H Young

(Address) 1036 N Calhoun

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 24 1917, to Sept. 10 1917, that I saw her alive on Sept. 8 1917, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

4 Mons (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

*(Signed) W. F. Dean M. D.

Sept 12, 191... (Address) 515 Hartford Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 12 191...

20-UNDERTAKER Samuel Beasley ADDRESS 5 Pratt St

SEP 12 1917 Harry C. Andrews Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8388

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

D 8388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hahnemann Hospital ST.; 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Franklin Godwin

(Residence in Baltimore: No. 807 N. Stricker St.; 65 yrs., 8 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, January (Month) 1st (Day), 1852 (Year)

7-AGE, 65 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: P. R. R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): 530 013

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Duncan Godwin

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sarah Jane Brown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Godwin

(Address) 807 N. Stricker St.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 12 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6th 1917, to Sept. 12 1917, that I saw him alive on Sept. 11 1917, and that death occurred, on the date stated above, at 8 40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) ? yrs. ? mos. ? ds.

(Signed) W. H. G. Jones M. D.

Sept. 13, 1917. (Address) 1235 W. Lafayette Ave

per E. S. Richards M.D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State 65 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence 807 N. Stricker St. this City

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Sept. 14, 1917.

20-UNDERTAKER Stewart Mooney ADDRESS 108 W. Mt. St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8389 ✓ D 8389

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 W. Presstman St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loucetta Cole

(Residence in Baltimore: No. 1612 W. Presstman St. 11 yrs., — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	married

6-DATE OF BIRTH, Nov (Month) 15 (Day), 1886 (Year)

7-AGE,	If LESS than 1 day,
30 yrs. 9 mos. 26 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lemuel Cole

(Address) 1612 W. Presstman

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 6 191 7, to Sept 11 191 7, that I saw her alive on Sept 10 191 7, and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

.....

Lobar Pneumonia

..... (Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

..... (Duration) — yrs. — mos. — ds.

(Signed) F. C. Link M. D.

Sept 11, 191 7 (Address) 1313 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, SEP 12 1917, 191...

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1612 PRESTMAN ST.

SEP 12 1917

D 8390

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

470 ✓

D 8390

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1958 S. Hanover ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME John Koch

(Residence in Baltimore: No. 1958 S. Hanover St. 25 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb. 1, 1845 (Month) (Day) (Year)

7 AGE: 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Koch

(Address) 1958 Hanover St

15 SEP 12 1917

Filed ....., 191.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 9, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1917, to Sept 9 1917, that I saw him alive on Sept 9, 1917, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY): Old age

(Duration) yrs. mos. ds.

(Signed) A Wolcott M. D.

Sept 12, 1917 (Address) 1279 William St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Sept 12, 1917

20 UNDERTAKER: M. D. Filpus ADDRESS: 1422 Light

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8391 + 28 ✓ D 8391

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. of Md. Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James McCombs Jr.

(Residence in Baltimore: No. Univ. of Md. Hospital St.; yrs., mos. 2/ ds.)

N.B.—Every item of information should be carefully supplied. AGE should be filled EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, January 30, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. 7 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer, editor 086
(b) General nature of industry, business, or establishment in which employed (or employer): Self 147

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, James McCombs

11-BIRTHPLACE OF FATHER (State or Country), [redacted]

12-MAIDEN NAME OF MOTHER [redacted]

13-BIRTHPLACE OF MOTHER (State or Country), [redacted]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Tuckey

(Address) North Pennsylvania

15-

Filed....., 191.....

SEP 12 1917 ROBERT R. KRAUTER Registrar.

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1917, to Sept 12 1917, that I saw him alive on Sept 12 1917, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) 3 yrs. mos. ds.

(Signed) [illegible] M. D.

....., 191... (Address) Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. X mos. 22 ds. In the State X yrs. X mos. 25 ds.

Where was disease contracted, if not at place of death? Florida ?

Former or usual residence Jacksonville, Fla.

19-PLACE OF BURIAL OR REMOVAL, Druid Park

DATE OF BURIAL, Sept 14, 1917.

20-UNDERTAKER W. E. Tuckey

ADDRESS North Pennsylvania Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8392 D 8392

CERTIFICATE OF DEATH.

Carryer

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 E Hughes St ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Wm J Carryer

(Residence in Baltimore: No. 137 E Hughes St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 9th, 1913
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Martinsburg W Va

PARENTS.

10-NAME OF FATHER, P. H. Carryer

11-BIRTHPLACE OF FATHER (State or Country), Bennington W Va

12-MAIDEN NAME OF MOTHER Lillie McGoodwin

13-BIRTHPLACE OF MOTHER (State or Country), Jefferson Co W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. H. Carryer

(Address) 137 E Hughes St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1917, to Sept 12th 1917, that I saw h[illegible] alive on Sept 12th 1917, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. 1 week ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) T. O'Donnell M. D.

Sept 12th, 191... (Address) 1617 Linn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. SEP 13 1917

20-UNDERTAKER ADDRESS Lay St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT [illegible]

SEP 12 1917 ROBERT R. KRAUTER ARMSTRONG-DENNY CO.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 8293 104 B 8293 3

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1319 Sargent St; St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alice E Carroll

(Residence in Baltimore: No. 1319 Sargent St; St.; yrs. 9 mos. 24 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK. DO NOT USE PENCIL.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: November 8, 1916 (Month) (Day) (Year)

7 AGE: yrs. 9 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Charles E Carroll

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Alice Wilkins

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Chas E Carroll

(Address) 1319 Sargent St

15.

Filed ....., 191 .....

REGISTRAR

SEP 12 1917 ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 11, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1917 to Sept 11 1917 that I saw h.. alive on Sept 11 1917 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ... yrs. ..... mos. 10 ds

Contributory (SECONDARY) Dyntition

(Duration) ... yrs. ..... mos. 15 ds.

(Signed) Raymond D Owen M. D.

Sept 14, 1917 (Address) 1727 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 19

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery. DATE OF BURIAL: Sept 13 1917

20 UNDERTAKER: John J Cowan Son ADDRESS: 901 Hollins St

Spec.—8-24-14—M. & T.—2000 Bks.

C8394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 738 S Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Szeligia (HELENA SZELIGA

(Residence in Baltimore: No. 838 S. Bond St.; ....yrs., 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. ..... July (Month) 30 (Day), 1917 (Year)

7-AGE. ....yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE. (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Adam Szeligi

11-BIRTHPLACE OF FATHER (State or Country), Galicia Austria

12-MAIDEN NAME OF MOTHER Barbara Parkosz.

13-BIRTHPLACE OF MOTHER (State or Country), Galicia Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Szeligi

(Address) 838 S. Bond

15-

Filed ....., 191.....

SEP 13 1917 ROBERT B. KRAUT Registrar. Burial Permit Issued

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 12 1917, that I saw h[er] alive on Sept 11th 1917, and that death occurred, on the date stated above, at 3.4 A m.

The CAUSE OF DEATH* was as follows:

..... Gastro Enteritis & Toxemia

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) ..... Bronchial Pneumonia

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) ..... M. D.

Sept 13, 1917 (Address) 1[illegible] N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept 13, 1917

20-UNDERTAKER Wm Falkowski — ADDRESS 618 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8395 ✓ 40 D 8395

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 N Belnord Ave St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Grant

(Residence in Baltimore: No. 534 N Belnord Ave St.; 17 yrs. mos. da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Not Known ....., 1..... (Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Thomas Klyzon

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grant

(Address) 534 N Belnord Ave

15-

Filed ....., 191.....

SEP 12 1917 ROBERT S. KRAUTH Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1917, to Sept 11 1917, that I saw h[illegible] alive on Sept 11 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. da.

(Signed) W. J. Rosser M. D.

Sept 13, 191.., (Address) 2008 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Hill	Sept 13 1917.
20-UNDERTAKER	ADDRESS
Frank Cracknell Son	1916 Eastland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8396

CERTIFICATE OF DEATH.

129 V

REGISTERED NO. C D. 8396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Velenvoski

(Residence in Baltimore: No. 832 N Chapel St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem. | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, (Month) Not Known, (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Frank Michael

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Fanne Conrad

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Velenvoski

(Address) 832 N Chapel St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5 1917, to Sept. 10 1917, that I saw her alive on Sept 10 1917, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

?

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Shock (Duration) yrs. 3 mos. ds.

(Signed) Benard A Fischer M. D.

9-10, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence ?

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Sept 13, 191.7

20-UNDERTAKER Frank Frank & Son | ADDRESS Walbert Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 W. Pratt St. 4 167 REGISTERED NO. C

2-FULL NAME Erasch Evano

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 426 W. Pratt st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. November 27, 1917
(Month) (Day) (Year)

7-AGE. 9 yrs. 15 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Cleveland Ohio

PARENTS.

10-NAME OF FATHER. Nicklas Evano

11-BIRTHPLACE OF FATHER (State or Country). Egypt

12-MAIDEN NAME OF MOTHER Lin Kee Uteskee

13-BIRTHPLACE OF MOTHER (State or Country). Egypt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicklas Evano

(Address) 426 W. Pratt St.

15-

Filed....., 191.....

ROBERT R. CRAUFURD
SEP 13 1917
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 9 1917, to 12 September 1917, that I saw him alive on 12 September 1917, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Disease 2nd Grade from operation
complete

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Double Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) C. H. A. Mayer M. D.

9.12, 191.7 (Address) 2438 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary — DATE OF BURIAL. S.9.12.17, 191.7

20-UNDERTAKER W. J. Ledwell — ADDRESS Mt. Pleasant

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(OK) a.n.s.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8393

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 567 Orchard ST.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Waters

(Residence in Baltimore: No. 567 Orchard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colo	Widow

6-DATE OF BIRTH, ... September, 1844
(Month) (Day) (Year)

7-AGE, ... 72 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer) 871

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), ~~Unknown~~ Va.

12-MAIDEN NAME OF MOTHER Madaline Green

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Waters

(Address) 567 Orchard St

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Labor)

..... (Duration) ..... yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Cold & Exposure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Sept 12, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Mt Auburn Cem	Sept 13, 1917

20-UNDERTAKER Samuel Hunter ADDRESS 5 [illegible]

SEP 13 1917 ROBERT A. KRAUTH Serial Form 1903

Spec.—8-24-14—M. & T.—2000 Bks.

D 8399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D 8399

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Harpur ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wise

(Residence in Baltimore: No. 2105 Harpur St.; 10 yrs., mos. ds.)

25 yrs in city

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. 13 (Month) (Day), 1870 (Year)

7-AGE, 45 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country) Culpepper Co Va.

PARENTS.

10-NAME OF FATHER, Joseph Wise

11-BIRTHPLACE OF FATHER (State or Country) Culpepper Co. Va

12-MAIDEN NAME OF MOTHER Fannie Higgins

13-BIRTHPLACE OF MOTHER (State or Country) Culpepper Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Wise

(Address) 2105 Harpur St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 19 1917, to Sept 10 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, Sept 13, 191.

20-UNDERTAKER Samuel Kemsley

ADDRESS 5 S Bloom Bridle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 13 1917 [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D 8400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8400

CERTIFICATE OF DEATH.

9 V

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3918 Elm Ave. St.; 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen B. Williams

(Residence in Baltimore: No. 3918 Elm Ave. St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Oct. (Month) 30 (Day), 1916 (Year)

7-AGE, ——yrs. 10 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

800

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Williams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sadie Schaffer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Williams

(Address) 3918 Elm Ave.

15-

Filed ....., 191....

Registrar.

SEP 11 1917 ROBERT B. KRAUTZ Deputy Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 191, to Sept 13 191, that I saw her alive on Sept 13 191, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchus

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

Sept 13 191.7 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, Sept 15, 191..

20-UNDERTAKER Horace Burgee Son — ADDRESS 3631 Falls Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Richard Adolph Helmrich

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8401 D 8402

CERTIFICATE OF DEATH.

REGISTERED NO. C 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard A. Helmrich

(Residence in Baltimore: No. 719 McHenry St.; 34 yrs. 3 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	single

6-DATE OF BIRTH, May 30 (Month) (Day) 1880 (Year)

7-AGE, 34 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Richard Helmrich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Leitheck

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Kirchhamer

(Address) 2217 Ruxton Ave

15-

Filed....., 191.....

Registrar.

SEP 13 1917 ROBERT M. ...

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 12 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 1917, to Feb. 12 1917, that I saw h[illegible] alive on Feb. 12 1917, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Delirium Tremens

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Wm. Hall M. D.

Feb. 12 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 719 McHenry St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Feb. 14, 1917

20-UNDERTAKER	ADDRESS
Bertram & Goetz	172 Redwood St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8402 — 104 — D 8402

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 N Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edward Stallings

(Residence in Baltimore: No. 1333 N Bond St Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 5 (Day), 1916 (Year)

7-AGE, 1 yrs. 4 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John E Stallings

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Clara Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Stallings

(Address) 1333 N Bond

15-

Filed ....., 191.... Registrar.

SEP 13 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4, 1917, to Sept 11 1917, that I saw him alive on Sept 11 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Pleuro Colitis

(Duration) .... yrs. .... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) John T Carey M. D.

Sept 11, 1917. (Address) 1603 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 13, 1917.

20-UNDERTAKER Wm Leach — ADDRESS 1702 E North ave

Spec. 8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 8403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S. Dallas St.; 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Mueller

(Residence in Baltimore: No. 720 S. Dallas St.; 84 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, Oct. (Month) 25, (Day) 1831 (Year)

7-AGE, 85 yrs. 11 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Hoffman

(Address) 720 S. Dallas St.

15-

Filed....., 191.....

Registrar.

SEP 13 1917 ROBERT B. FRAZIER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Aug. (Day) 12, (Year) 1917.

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1917, to Aug 12 1917, that I saw h alive on Aug 11 1917, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) 1 yrs. mos. ds.

(Signed) Fred. Frederick M. D.

Aug 13, 1917. (Address) 2230 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leasts Cem

DATE OF BURIAL, Aug 14 1917

20-UNDERTAKER Wm Cook

ADDRESS 802 E Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8401

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt. St.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie R. Maddox.

(Residence in Baltimore: No. 2809 Greenmount ave St.; 23 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... June (Month) ....., 1856 (Day) (Year)

7-AGE,	If LESS than 1 day,
61 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John M. Maddox

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah J. McDaniel

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Maddox

(Address) 2809 Greenmount

15-

SEP 13 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1917, to Sept. 12 1917, that I saw her alive on Sept. 12, 1917, and that death occurred, on the date stated above, at 8.55 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insuff.

..... (Duration) Unknown

CONTRIBUTORY (Secondary) Mitral disease

..... (Duration) Unknown

(Signed) B. B. Brumbaugh M. D.

Sept. 14 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 27 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence 2809 Greenmount Ave

19-PLACE OF BURIAL OR REMOVAL, Mt. View Cemetery DATE OF BURIAL, Sept. 14, 1917

20-UNDERTAKER William Cook ADDRESS 501 E. Fort Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8405

CERTIFICATE OF DEATH.

50 ✓ D 8405

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Wyanoke Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rebecca Cale

(Residence in Baltimore: No. 609 Wyanoke Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb. 5th, 1844
(Month) (Day) (Year)

7-AGE, 73 yrs. 7 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Lemuel Krebs.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza Batchlor.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Worthington

(Address) 609 Wyanoke Ave

15-

Filed ....., 191.....

SEP 13 1917 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1908, to Sept 11 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 4 mos. ds.

(Signed) John Evans M. D.

Sept. 11, 1917. (Address) 20 E. Franklin Terrace

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR ~~REMOVAL~~, Baltimore County

DATE OF BURIAL, Sept 13, 191...

20-UNDERTAKER William Cook

ADDRESS 508 N. Howard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 ✓

D 8406

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N. Ware ST.: 6 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Eder

(Residence in Baltimore: No. 119 N. Ware st. St.: 21 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept. 24, 1895 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 11 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Boarmaile

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Pitel

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Erasmus Eder.

(Address) 119 N. Ware st.

15-

Filed....., 191.....

Registrar.

SEP 13 1917 ROBERT B. KRAUTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1917, to Sept. 11 1917, that I saw h alive on Sept. 11 1917, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Retained Placenta

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. N. McGarvey M. D.

Sept. 13, 1917 (Address) 1726 E. Baltimore

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	Sept. 14, 1917

20-UNDERTAKER	ADDRESS
Jos. J. Kerr	156 N. Eutaw

Spec.—8-24-14—M. & T.—2000 Blks.

D 8407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8407

104

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Barclay ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence M. Johnson.

(Residence in Baltimore: No. 3120 Barclay St.; ..... yrs., 10 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... May (Month) ..... 15 (Day), 1916 (Year)

7-AGE, ... yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Lawrence Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Marchant

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence Johnson

(Address) 3120 Barclay St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) ..... 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2, 191 7, to Sept. 12 191 7, that I saw h[illegible] alive on Sept. 10 191 7, and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

..... Cirrhosis - Colitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) W. F. Campbell M. D.

Sept 13 191 7 (Address) 215 Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery

DATE OF BURIAL, Sept. 14, 1917

20-UNDERTAKER John A. Pentz

ADDRESS 1[illegible] Pine St

D 8408

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8408

1 PLACE OF DEATH

REGISTERED No. C 6 79

CITY OF BALTIMORE (No. 238 N Patterson Pk. ave ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Yicke

(Residence in Baltimore: No. 238 N. Patterson Park ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH ..... Mar. 24, 1840
(Month) (Day) (Year)

7 AGE ..... 77 yrs. 6 mos. 16 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ..... House work
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (State or country) Balto

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. E. Yicke

(Address) 238 N Patterson Park ave

15 SEP 13 1917 ROBERT B. KRAFT

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 10, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1917, to. Sept 10 1917, that I saw h[illegible] alive on Sept 10, 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed), Geo E Lyoung M. D.

....., 191 (Address) E. Eighth ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dublin [illegible]	Sept 13, 191 7

20 UNDERTAKER C. E. Fleming | ADDRESS 1932 Eastern ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 8109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2187 Bradford Ave. ST.; WARD) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Coates,

(Residence in Baltimore: No. 2187 Bradford Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE. 34 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Coates

(Address) 2187 Bradford Ave

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 10 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SEP 13 1917

ROBERT E. KRAUSE
Sanitary Engineer
Commissioner of Health.

146

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8410 D 8410

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kelly.

(Residence in Baltimore: No. 1 Orleans St.: ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Married.

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 66 yrs. ....mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General 044 0
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Maryland Penitentiary

15-

Filed....., 191.....

Registrar.

SEP 13 1917 ROBERT R. KRAUTH Commissioner Health.

5145

Morgue

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 7, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April- 4 1917, to September 7 1917, that I saw him alive on September- 7- 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - Arteriosclerosis (Alcoholic). Senile Dementia.

..... (Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Senility.

..... (Duration) ....yrs. 4 mos. 20 ds.

(Signed) William F. Schwarz M. D.

Sept- 8, 1917. (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 4 mos. 20 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Orleans St.

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

JOHNS HOPKINS HOSPITAL

Burial Permit Issued Commissioner Health.

Per. Wm. H. WELBALE

Spec.—8-24-14—M. & T.—2000 Bks.

D 8111

HEALTH DEPARTMENT—CITY OF BALTIMORE

8111

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 Columbia Ave ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Irene Sprinkel

(Residence in Baltimore: No. 843 Columbia ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	single

6-DATE OF BIRTH, Sept. (Month) 4 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
yrs. mos. 8 ds.	hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George W. Sprinkel

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Irene Rebhuhn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Sprinkel

(Address) 843 Columbia ave

15-

Filed SEP 13 1917, 191.

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept. 12 1917, that I saw h[er] alive on Sept 12 1917, and that death occurred, on the date stated above, at 5[30] p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. McIntyre M. D.

Sept 12, 1917 (Address) 32 E. Columbia ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem.	Sept 13, 191..
20-UNDERTAKER	ADDRESS
Geo Leinbrock & Sons	647 N. Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8412

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8412

154

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Home for Incurables St. 12 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Ellen C. H. Taylor

(Residence in Baltimore: No. Home for Incurables St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Unknown (Month) (Day), 1845 (Year)

7 AGE: 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 068

9 BIRTHPLACE (State or country): Unknown

PARENTS

10 NAME OF FATHER: Geo Parker

11 BIRTHPLACE OF FATHER (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Home for Incurables

(Address) Guilford Ave & 21st St.

15

Filed SEP 13 1917, 191

ROBERT E. CRAUTH

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1913, to Sept 1917, that I saw h-r alive on Sept. 12, 1917, and that death occurred, on the date stated above, at 2 a. m., The CAUSE OF DEATH* was as follows:

Fractured hip.

(Duration) 10 yrs. mos. ds

Contributory (SECONDARY) Infirmities of age

(Duration) yrs. mos. ds.

(Signed), C. H. Taylor M. D.

Sept 13, 1917 (Address) 2413 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 14, 1917

20 UNDERTAKER: H. E. Hughes

ADDRESS: 17 S. Howard

D 8413

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C 1720 ✓ D 8413

CITY OF BALTIMORE (No. 1528 E Biddle St — 8 — WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bertha Kegeeter

(Residence in Baltimore: No. 1528 E Biddle — St.: 67 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH: August 5, 1838 (Month) (Day) (Year)

7 AGE: 79 yrs. 1 mos. 1 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): England

PARENTS

10 NAME OF FATHER: Wm Lucas

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah Krasnick

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. E Collison

(Address) 1525 E Biddle St.

15

Filed ..... 191 ..... REGISTRAR

SEP 13 1917 ROBERT P. HEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 11, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1917, to Sept 11 1917, that I saw h— alive on Sept 11, 1917, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo F Lamm M. D.

Sept 12, 1917 (Address) 1531 E Fourth St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 15, 1917

20 UNDERTAKER	ADDRESS
H. E Hafer	N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 8414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] St. [illegible] WARD)

REGISTERED No. C 189

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [illegible]

(Residence in Baltimore: No. [illegible] St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Married

6-DATE OF BIRTH, May (Month) 16 (Day), 1874 (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Elizabeth Hyde

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Guy C. Millholland

(Address) Richmond Va.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

Sudden. (Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..yrs. ..mos. ..ds.

(Signed) H. T. Riley M. D.
(Coroner.)

Sept. 11, 1917. (Address) 639 Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Sept. 14, 1917
20-UNDERTAKER	ADDRESS
H. W. Mears & Son	805 N. Calvert St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8415

CERTIFICATE OF DEATH.

D 8415

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Augusta Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. O'Neill

(Residence in Baltimore: No. 8 Augusta Ave St.: ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 18, 1866 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
51 yrs.....mos.....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 609

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Owen O'Neill

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Elizabeth Byrne

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. O'Neill

(Address) 8 Augusta Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Sept 12 1917, that I saw him alive on Sept 10 1917, and that death occurred, on the date stated above, at 3.45 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) 2 yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) W. A. Lucas M. D.

Sept 13, 1917. (Address) 4207 Frederick Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Catholic Cemetery	Sept. 15, 1917.
20-UNDERTAKER	ADDRESS
Albert E. Fuller	521 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 8416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8416

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 E. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E Taylor

(Residence in Baltimore: No. 1608 E. Lanvale St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 17, 1829
(Month) (Day) (Year)

7-AGE, 88 yrs. 1 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cooper as Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Self 017

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Samuel Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma Furman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Taylor

(Address) 1608 E. Lanvale St

15-

Filed ..., 191...

Registrar.

SEP 13 1917 ROBERT B. KRAUTH REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1917, to Sept. 11, 1917, that I saw him alive on Sept. 8 1917, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
(Senile)
(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic
(Duration) ... yrs. ... mos. 1 ds.

(Signed) C. E. Curtis M. D.

9-14, 1917. (Address) Chas. & Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem.	Sept. 14, 1917.
20-UNDERTAKER	ADDRESS
Albert E. Fuller	221 N. Bradford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8417 — 128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Jefferson St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fiston Taylor

(Residence in Baltimore: No. 1410 Jefferson St.; ... yrs., ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 189?

7-AGE, 19 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Amanda Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie E. Mason

(Address) 1649 E. Monument St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 1917, to Sept., 1917, that I saw him alive on Sept. 11, 1917, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ... yrs. 3 mos. ... ds.

(Signed) H. K. Mills M. D.

Sept. 12, 1917 (Address) 1320 Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Cemetery

DATE OF BURIAL, Sept. 14th, 1917

20-UNDERTAKER Chas. G. Ridgely

ADDRESS N. Howard St

SEP 13 1917

ROBERT R. CRAUTER
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8118 — D 8118

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Lunny

(Residence in Baltimore: No. 1020 N. Gay St. St.; — yrs., — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word.)
Male	White	Single

6-DATE OF BIRTH, July 10, 1897 (Month) (Day) (Year)

7-AGE, 20 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): " 086

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, James Lunny

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Cecelia Sunyer

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Lunny

(Address) Camp Mead, Admiral

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4 1917, to Sept 8 1917, that I saw h im alive on Sept. 8 1917, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Coma

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Sept. 8, 191 7. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State Dont know yrs. mos. ds.

Where was disease contracted, if not at place of death? 1020 N. Gay St

Former or usual residence 1020 N. Gay St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
White Plains N Y	Sept 10, 1917
20-UNDERTAKER Henry W. Meagher Son	ADDRESS 805 Calvert

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DE[illegible]'NT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST.; 5 WARD) REGISTERED NO. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Brodie

(Residence in Baltimore: No. 1222 E. Lexington St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1860 (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: peddler
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Record

(Address) Hebrew Hosp

15-

Filed SEP 13 1917, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1917, to Sept 12 1917, that I saw her alive on Sept 12 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Bernard Grossman M. D.

Sept 13, 1917 (Address) 1 Hebrew Hosp Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 19 ds. In the State 50 yrs. mos. ds.

Where was disease contracted, if not at place of death? 1222 E. Lexington St

Former or usual residence 1222 E. Lexington St

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem DATE OF BURIAL, 9-14-1917

20-UNDERTAKER D. Goodheim ADDRESS 918 Park Royal Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8420

1 PLACE OF DEATH — Registered No. C 151

CITY OF BALTIMORE (No. 1730 Maryland St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME (Baby) Leuhrt

(Residence in Baltimore: No. 1730 Maryland St.: yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept 11, 1917 (Month) (Day) (Year)

7 AGE: yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Leuhrt

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Rosie Pellegrini

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Rosie Leuhrt

(Address): 1730 Md Ave

15.

Filed SEP 13 1917, 191. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 11, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191 , to. 191 .

that I saw h alive on .191 .

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(b) Premature Birth

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Reuben Dow M. D.

Sept 11, 1917 (Address) 1730 Md Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Vincent — DATE OF BURIAL: Sept 12, 1917

20 UNDERTAKER: H S Marshall — ADDRESS: 2539 Fallsway

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C 55008

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1730 Maryland Ave St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katy Lenhart

(Residence in Baltimore: No. 1730 Md Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept 11, 1912 (Month) (Day) (Year)

7 AGE: yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 880

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Lenhart

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rose Pellegrini

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Lenhart

(Address) 1730 Md. Ave

15.

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191 , to 191 ,

that I saw h alive on 191 .

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

6 Months Tuberculosis

Peritonitis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 11, 191 7 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Vincents | DATE OF BURIAL: Sept 12, 1917

20 UNDERTAKER: H. S Marshall | ADDRESS: 3559 Falls Rd

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8422

CERTIFICATE OF DEATH.

X94

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Simmons

(Residence in Baltimore: No. Sulley - Md St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	black	single

6-DATE OF BIRTH, unknown., 1 (Month) (Day) (Year)

7-AGE, ...yrs. 16 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Sulley - Md.

PARENTS.

10-NAME OF FATHER, unknown.

11-BIRTHPLACE OF FATHER (State or Country), unknown.

12-MAIDEN NAME OF MOTHER Pearl Simmons

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1917, to Sept 8 1917, that I saw h[illegible] alive on Sept 8 — 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

3 mos

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) hypostatic pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Sept 8, 1917 (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 35 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Sulley - Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS
Commissioner Health.	

H. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8123

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Mendel

(Residence in Baltimore: No. 1628 Lansing ave. St.; 1/2 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngl

6-DATE OF BIRTH, October 2, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), md.

PARENTS.

10-NAME OF FATHER, Leopold Mendel

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Katie Hole

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps

(Address) Johns Hopkins Hosp.

15-

HARRY C. ANDREWS
SEP 19 1917
Registrar of Vital Statistics

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 13 1917, that I saw h[illegible] alive on Sept 12 1917. and that death occurred, on the date stated above, at 2 25 a. m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis acute

(Duration) 0 yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) 0 yrs. 0 mos. 21 ds.

(Signed) Henry B. Convers M. D.

Sept. 13, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death —yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1628 Lansing Ave.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Sept 13, 1917.

20-UNDERTAKER Kelly & Burns ADDRESS 1142 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8121 D 8121

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 N. Montford ave ST.; 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Robinson

(Residence in Baltimore: No. 120 N. Montford ave St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Sept 11, 1917 (Month) (Day) (Year)

7-AGE, ...yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ... None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Robt B. Robinson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Emma Harmon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ...

(Address) ...

15-

Filed SEP 13 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 11 1917, that I saw h... alive on Sept 11 1917, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Premature Infant
Aborted about 4 th month
Dr. Emmanuel Burdsall
15 Minutes (Duration) ...yrs. ...mos. 15 Mi ds.

CONTRIBUTORY (Secondary) Premature Labor
Dr. Manning Sinus
(Duration) ...yrs. ...mos. ...ds.

(Signed) W. C. Burns M. D.

Sept 12, 1917. (Address) 2218 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL ..., 1
20-UNDERTAKER	ADDRESS

Burial Permit Issued

5149

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 3425 D 3425 104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N Rose ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mergl

(Residence in Baltimore: No. 702 N Rose St.; ..... yrs., 2 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, ... July (Month) 2 (Day), 1917 (Year)

7-AGE.	If LESS than 1 day,
..... yrs. 2 mos. 11 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Mergl

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Dalny

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Mergl

(Address) 702 N Rose St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 13 1917, that I saw h.m alive on Sept 13 1917, and that death occurred, on the date stated above, at 2.45P m.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. S. Rumbaugh M. D.

Sept. 13, 1917. (Address) 604 N Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Sept 14, 1917.
20-UNDERTAKER	**ADDRESS**
Frank Crack Son	1906 Eastlake

NOTE.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186 D 8426

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 936 Augusta St. ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dispasquale.

(Residence in Baltimore: No. 936 Augusta St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White Italian

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, September (Month) ..... (Day), 1900 (Year)

7-AGE, 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Jos Dispasquale

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mickela Salerno

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Rosaro

(Address) 920 Augusta St

15-

Filed ....., 191.....

SEP 13 1917 HARRY C. ARTZBERG Registrar of Births & Deaths

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 8 1917, to Sept 12 1917, that I saw him alive on Sept. 12 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

General Sepsis (septicemia)
Caused by running nail in foot while working)
..... (Duration) ..... yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis, Heart Failure
..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Harry Goldberg M.D.

9/12, 1917. (Address) 2031 W Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Sep 14, 191.7

20-UNDERTAKER Geo J Ruth

ADDRESS 1735 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Emilia Kropp.

D 8127

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D 8127

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 861 Dallas ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emilia Kropp

(Residence in Baltimore: No. 861 S. Dallas St.: 5 yrs., 11 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 25 (Day), 1912 (Year)

7-AGE, 4 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Felix Kropp

11-BIRTHPLACE OF FATHER (State or Country), Austria Poland

12-MAIDEN NAME OF MOTHER Antonia Ferrino

13-BIRTHPLACE OF MOTHER (State or Country), Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Kropp

(Address) 861 S. Dallas St.

15-

SEP 13 1917

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 191 7, to Sept 12 191 7, that I saw her alive on Sept 12 191 7, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis 3 days

Collapse

(Duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Influenza & Bronchopneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Thos. H. Buckler M. D.

Sept, 191... (Address) 1621 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Sept 14 191 7.

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

Registered No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Thames St.; 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angeline Wasielewski.

(Residence in Baltimore: No. 1817 Thames St.; yrs. 11 mos. 17 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: September 26th, 1916. (Month) (Day) (Year)

7-AGE: yrs. 11 mos. 17 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: — None
(b) General nature of industry, business, or establishment in which employed (or employer): —

880 880

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: James Wasielewski

11-BIRTHPLACE OF FATHER (State or country): Russia Poland.

12-MAIDEN NAME OF MOTHER: Agnes Stojnacki

13-BIRTHPLACE OF MOTHER (State or country): German Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes Wasielewska

(Address) 1817 Thames St.

15-

Filed ....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. 13 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1917, to, Sept 13 1917, that I saw her alive on Sept 12 1917 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. — mos. 5 ds.

Contributory (SECONDARY) Exhaustion

(Duration) yrs. — mos. 1 ds.

(Signed) W. C. Stadler M. D.

....., 191..... [Address] 143 N. Eden

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Sept 14, 1917

20-UNDERTAKER: M. F. Sadowski ADDRESS: 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Montpelier St.) (Ward) 2

REGISTERED NO. C 130

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. Johnson

(Residence in Baltimore: No. 427 Montpelier St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED? (Write the word.) Married

6-DATE OF BIRTH, May 16, 1862 (Month) (Day) (Year)

7-AGE, 55 yrs. 3 mos. 27 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Johnson

(Address) 427 Montpelier St.

15-

Filed ....., 191....

Registrar.

SEP 14 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1917, to Sept 12 1917, that I saw h— alive on Sept 12 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Bright Disease

..... (Duration) ....yrs. 4 mos. ....da.

CONTRIBUTORY (Secondary) Pericarditis

..... (Duration) ....yrs. 1 mos. 15 da.

(Signed) H. Garland Thomas M. D.

Sept 12, 1917. (Address) 1524 E. H. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Patapsco

19-PLACE OF BURIAL OR REMOVAL, Walkerel Cemetery

DATE OF BURIAL, Sept. 14, 1917.

20-UNDERTAKER Robt. H. Pye

ADDRESS 102 E. Hamburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. 1317 Presstman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Burg - Barratt

(Residence in Baltimore: No. 1317 Presstman St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1890 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: John Burg -

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Carrie Brown

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Burg-Wrch

(Address) 2026 N 17th St Phila Pa

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 191 , to Sept 12 191 , that I saw h[illegible] alive on Sept 12 191 , and that death occurred, on the date stated above, at 5.20 p.m.

The CAUSE OF DEATH* was as follows:

Pre Labor Tuberculosis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Pre Bronchitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edward Short M. D.

Sept 13, 191... (Address) 1813 Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Zion — DATE OF BURIAL, Sept 16, 1917.

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 N Bway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8431

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1404 N. Bruce St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Dunit

(Residence in Baltimore: No. 1404 N. Bruce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, [illegible]

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) [illegible]

6-DATE OF BIRTH, Dec. 6, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, W. B. Dunit

11-BIRTHPLACE OF FATHER (State or Country), Balt.

12-MAIDEN NAME OF MOTHER, Martha Nelson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST ~~OF~~ MY KNOWLEDGE.

(Informant) Mordine

(Address) 1404 N. Bruce

15-

Filed....., 191....

Registrar.

SEP 14 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible]
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(Duration) yrs. mos. ds.

(Signed) P. McMahon M. D.
(Coroner.)

Sept 13, 1917 (Address) 1 E. Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State [illegible]yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept 14 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N Bruce

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THE DATES

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8132

CERTIFICATE OF DEATH.

D 8132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Pine ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wilson

(Residence in Baltimore: No. 502 N Pine St; yrs. 17 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Apr. (Month) ..... (Day), 1900 (Year)

7-AGE, 17 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Grant

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Depont

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Grant

(Address) 502 N. Pine St.

15-

Filed....., 191.....

SEP 14 1917

ROBERT R. CHATTEN

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12th (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Aug 24th 1917, to Sept 12th 1917, that I saw h[illegible] alive on Sept 11th 1917, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

17 days

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D.

Sept 12th 1917 (Address) 607 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Sept 14th, 1917

20-UNDERTAKER Samuel Beasley

ADDRESS 1518 Bolton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8433

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 116 Albemarle St. St.: 3 WARD)

2-FULL NAME Charles Valore (Charles Valone)

(Residence in Baltimore: No. 116 Albemarle St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 hours

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 13, (Month) (Day) 1917 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Valone

11-BIRTHPLACE OF FATHER (State or Country) Italy

12-MAIDEN NAME OF MOTHER Maria Massa

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Valone

(Address) 116 Albemarle St

15-

Filed....., 191.....
Registrar.

SEP 11 1917 ROBERT E. KRAUSE
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin Hyde Guthrie M. D.
(Coroner.)

9-11-1917, 191... (Address) 100 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincents	Sept 15, 1917

20-UNDERTAKER	ADDRESS
William Faulkowski	116 Carlton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8131

CERTIFICATE OF DEATH.

64 8131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 E. Lombard ST.; 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Altfeld

(Residence in Baltimore: No. 2213 E. Lombard St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1871 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Mendel Altfeld

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Etta Perrin Yankauer

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St

15-

Filed ....., 191.....

Registrar.

SEP 14 1917

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 13 1917, that I saw him alive on Sept 13 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 0 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel Silverstein, M. D.

....., 191... (Address) 1121 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Balto Co. DATE OF BURIAL, 9/14/1917

20-UNDERTAKER Southern and Jack Lewis ADDRESS 1411 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE WITH INDELIBLE INK—THIS CERTIFICATE SHOULD BE CAREFULLY PREPARED. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D 8135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 8135

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Patapsco ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo Fursch

(Residence in Baltimore: No. 1738 Patapsco St ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Aug (Month) 22 (Day), 1884 (Year)

7-AGE,	If LESS than 1 day,
33 yrs. 19 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Electro
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Typer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ernest Fursch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Sotter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Fursch.

(Address) 1738 Patapsco

15-

Filed ..... SEP 14 1917 ....., 191.....

ROBERT R. TRAUTZ
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1. 191 7, to Sept 11 191 7, that I saw h[illegible] alive on Sept 10 191 7, and that death occurred, on the date stated above, at 8 pm m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Trautz M. D.

Sept 12, 191... (Address) 1738 Patapsco

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Sept. 15, 191 7.
20-UNDERTAKER C. Schlosnagle	ADDRESS 1039 Hollins St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

USE INDELIBLE INK—PREFERABLY BLACK

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8136 — 36 — D 8136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Ridgely St ST. 7th WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Sackhoff

(Residence in Baltimore: No. 924 Ridgely St.; 46 yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 9 (Day), 1 (Year)

7-AGE, 46 yrs. ..... mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. H. Sackhoff

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Hulda Kollmeyer

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Sackhoff

(Address) 611 W. Pratt St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1915, to Sept 13 1917, that I saw her alive on Sept 13 1917, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) 2 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Fracture femur tibia fibula

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) H. E. Krantz M. D.

Sept 14, 1917. (Address) 1062 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Westview Cem. — DATE OF BURIAL, Sept 16, 1917

20-UNDERTAKER Ottmann & Son — ADDRESS 1034 Hanover St

CAUSE OF DEATH—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8137

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Myrtle ave ST.: 17 WARD)

2-FULL NAME Talbott T Gosnell

(Residence in Baltimore: No. 1043 Myrtle ave

St.: 64 yrs., 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE,~~ MARRIED, ~~WIDOWED,~~ OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Mar (Month) 20 (Day), 1853 (Year)

7-AGE, 64 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or ....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Planter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John T Gosnell

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mary Elliott

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... John T Gosnell

(Address) ..... 1043 Myrtle Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13, 1917, to Sept 14, 1917, that I saw h~~im~~ alive on Sept 13, 1917, and that death occurred, on the date stated above, at 5-20 a m.

The CAUSE OF DEATH* was as follows:

.....
Apoplexy
.....
..... (Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

..... (Duration) 1 yrs. 2 mos. about

(Signed) H W King M. D.

....., 191... (Address) 6 E 1 N Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 17, 191 7

20-UNDERTAKER David Easton

ADDRESS 916 Penna ave

SEP 1 1917

ROBERT R. KNOTTS
Burial Permit Clerk

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITING INK—THIS IS A PERMANENT RECORD

D 8433

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 1730

CITY OF BALTIMORE (No. 1113 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Hooper Kleinfelter

(Residence in Baltimore: No. 1113 W. Lanvale St.; living Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct (Month) 30 (Day) 1835 (Year)

7 AGE: 81 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Hsw

9 BIRTHPLACE (State or country): Balto., Md

PARENTS

10 NAME OF FATHER: Wm. E. Hooper

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Bell

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Van V. Kleinfelter

(Address) 1113 W. Lanvale St

15.

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 12 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 4", 1917, to Sept. 12" 1917, that I saw h w alive on Sept. 11" 1917, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) Don't Know yrs. mos. ds

Contributory (SECONDARY) General Senility

(Duration) yrs. mos. ds.

(Signed) Wm B. Fidler M. D.

Sept. 13, 1917 (Address) 86 Harlem Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Druid Mount — DATE OF BURIAL: Sept 14, 1917

20 UNDERTAKER: Jno O. Mitchell — ADDRESS: 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8439

HEALTH DEPARTMENT—CITY OF BALTIMORE

126 D 8439

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Bay st ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Shipley.

(Residence in Baltimore: No. 737 Bay st St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, June (Month) 14 (Day), 1846 (Year)

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto Co

PARENTS.

10-NAME OF FATHER, Charles Shipley

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Shipley

(Address) 737 Bay st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st 1917, to Sept 13th 1917, that I saw him alive on Sept 13 1917, and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic Arterial Sclerosis

Senility (Duration) yrs. mos. ds.

(Signed) J. B. A. Tillison M. D.

Sept 14, 191.. (Address) 427 Union Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Balto Co.

19-PLACE OF BURIAL OR REMOVAL, Wolfe-Lynn

DATE OF BURIAL, Sept 17, 1917

20-UNDERTAKER Wyatt & Nock

ADDRESS 387 E North Ave

Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

WRITING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8140 — 80 — D. 8140

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Rose ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Baummer

(Residence in Baltimore: No. 103 N Rose St St., 67 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Don't Know (Month), 1 (Day) ..... (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Don't know.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Don't know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Baummer

(Address) 103 N. Rose St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 12 1917, that I saw h— alive on Sept 10 1917, and that death occurred, on the date stated above, at 9 P (m.

The CAUSE OF DEATH* was as follows:

General Angina
Pectoris

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Hypertrophy Fatty Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Mark M. D.

Sept 12, 1917. (Address) 2120 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept. 15, 1917

20-UNDERTAKER Wm. Cook — ADDRESS 503 E Monument

IMPORTANT—THIS IS A PERMANENT RECORD
PENDING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Schneider

(Residence in Baltimore: No. 2023 Kennedy Ave St.: 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1862
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, H. Sulthans

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Kaiser

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Schneider

(Address) 2023 Kennedy Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) – 12 (Day) –, 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Sept 12 1917, that I saw her alive on Sept 12 - 1917, and that death occurred, on the date stated above, at 8.15 m.

The CAUSE OF DEATH* was as followa:

Carcinoma Uteris and ovaries with metastases to liver intestines and pleurae.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept 15, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2023 Kennedy Ave

Former or usual residence 2023 Kennedy Ave

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept. 15 1917.

20-UNDERTAKER Ulm Bros. ADDRESS 502 E Ward.

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PRINTING INK—THIS IS A PERMANENT RECORD

D 8412

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8412

REGISTERED No. C 1760

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 638 N. Ferth St. 13 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bonn

(Residence in Baltimore: No. 638 West Nath Ave St. 92 yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH: January (Month) 20 (Day), 1825 (Year)

7-AGE: 92 yrs. 9 mos. 7 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Don't know

11-BIRTHPLACE OF FATHER (State or country) Don't know

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or country) Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adele E. Wilkinson

(Address) 638 W. North Ave

15. Filed SEP 14 1917, 191 ROBERT E. KRAUSE Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept (Month) 13th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11th, 1917, to Sept 13th 1917, that I saw h[illegible] alive on Sept 11th, 1917, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Old age

(Duration) 1 yrs. mos. ds.

(Signed) J. L. Lehnert M. D.

9/13, 1917 (Address) 211 N. Jamard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount Cem | DATE OF BURIAL Sept 14 1917

20-UNDERTAKER Wm. Cook | ADDRESS 522 E. North

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8413

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N. Broadway ST.; 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Cohen

(Residence in Baltimore: No. 4 N. Broadway St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 22 (Day), 1899 (Year)

7-AGE, 18 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school Girl
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Baltimd

PARENTS.

10-NAME OF FATHER, Louis Cohen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rachael Davis

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1914, to Sept 14 1917, that I saw h[illegible] alive on September 13 1917, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Wm. J. Hatson M. D.

Sept 14, 1917. (Address) 2117 E. St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodeph | DATE OF BURIAL, Sept 14, 1917

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E. Balto

THIS IS A PERMANENT RECORD—WRITE WITH UNFADING INK

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8417

CERTIFICATE OF DEATH.

REGISTERED NO. C 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Moore

(Residence in Baltimore: No. 1706 N Bethel St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, 9 (Month) 13 (Day), 1917 (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 1 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....Boy....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Moore

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret O'Leary

13-BIRTHPLACE OF MOTHER (State or Country), N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Moore

(Address) 1706 N. Bethel St

15-

Filed ....., 191....

Registrar.

SEP 14 1917

ROBERT B. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 191 7, to Sept 13 191 7, that I saw h[illegible] alive on Sept 13 191 7, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Livida

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Ernest P. Rogers M. D.

9/13, 191.7 (Address) St Joseph Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. 1 ds.

Where was disease contracted, if not at place of death? St Joseph Hospital

Former or usual residence St Joseph Hospital

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Sept 14, 191.7

20-UNDERTAKER Henry Horch Son

ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

—THIS IS A PERMANENT RECORD—WRITE WITH UNFADING INK

W. George Wills

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hosp ... St. ... WARD)

REGISTERED No. C 9 + 175

D 8415

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. Geo Wills

(Residence in Baltimore: No. 57 Lauchman St.; yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 284

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Sept (Day) 20, (Year) 1850

7-AGE, 36 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) ... Contractor

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Joseph Wills

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Wills

(Address) 57 Lauchman

15-

SEP 14 1917

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Sept (Day) 12, (Year) 1917

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. K. Quinlan M. D. (Coroner.)

Sept 12, 1917 (Address) 32 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Keoby Redeemer Cemy	Sept 15, 1917

20-UNDERTAKER	ADDRESS
Henry Storch & Son	1330 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8446 — 10 — D 8446

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Frisby ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Jeffers

(Residence in Baltimore: No. 2819 Frisby St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Child

6-DATE OF BIRTH, Sept. 16, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 27 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Philip C. Jeffers

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Emma M. Gebhart

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma M. Jeffers

(Address) 2819 Frisby St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 13 1917, that I saw h— alive on Sept 13 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Jones M. D.

Sept 13, 1917. (Address) 837 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Sept. 15, 1917

20-UNDERTAKER Robt. J. Turner — ADDRESS 1442 N Broadway

SEP 1? 1917 ANDREW H. KRAUTER Burial Permit

NG INK—THIS IS A PERMANENT RECORD
ied. AGE should be stated EXACTLY. PHYSICIANS should state
be properly classified. Exact statement of OCCUPATION is very
Every item of information should be carefully supplied.
CAUSE OF DEATH in plain terms, so that it may be
important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8417

28 ✓

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 E Hull ST.; Waverly 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Kelley

(Residence in Baltimore: No. 630 E Hull St. St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept 22, (Month) (Day), 1868. (Year)

7-AGE, 49 yrs. ..... mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... (3)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. Son.

(Informant) J. Henry Huntsch

(Address) 630 Hull St

15-

SEP 11 1917

ROBERT R. REAMY
Burial Permit Clerk

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12, (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Sept 12 1917, that I saw h.. alive on Sept 12 1917, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

.....

Tuberculosis

..... (Duration) ..... yrs. 4 mos. 12 ds.

CONTRIBUTORY (Secondary) Cong. Exhaustion

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H Robinson M. D.

Sept 13, 191 7. (Address) 726 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Sept 15, 191 7.

20-UNDERTAKER [redacted] — ADDRESS Robert E Turner 1729 N. Broadway

P. S. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

PRINTING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Adams St. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. Froscup

(Residence in Baltimore: No. 2311 Adams St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, December 7th, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Froscup

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Jneed.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Froscup

(Address) 2311 Adams St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12th 1917, to Sept. 12th 1917, that I saw h— alive on Sept. 12th 1917, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Marasmus
Chronic Intestinal Toxemia

(Duration) ....yrs. 9 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo A. Young M.D. M. D.

Sept 12th, 1917. (Address) 2337 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet — DATE OF BURIAL, Sept. 14 1917

20-UNDERTAKER C. A. Weatherhead — ADDRESS Green & Mt Ave

THIS IS A PERMANENT RECORD—WRITE WITH INDELIBLE INK

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Central Ave St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Myers

(Residence in Baltimore: No. 212 N Central Ave St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., (Year) 1

7-AGE, 50 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Jessie Cain Pugh

(Address) 212 N Central Ave

15- Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14th 1917, to Sept 13th 1917, that I saw him alive on Sept 13th 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Contributory)

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Hypostasis

(Duration) ... yrs. Unknown mos. ... ds.

(Signed) C Gordon M. D.

Sept 14th 1917. (Address) 607 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, North Point Cem. DATE OF BURIAL, Sept 15, 1917.

20-UNDERTAKER Wm R A Elliott ADDRESS 506 East [illegible]

IMPORTANT—THIS IS A PERMANENT RECORD—WRITE WITH INDELIBLE INK

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138

D 8450

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 W Fairmount Ave St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie M. Buppert

(Residence in Baltimore: No. 2111 W. Fairmount ave. Life time yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~ Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, Sept 9th (Month) (Day), 1884 (Year)

7-AGE, 33 yrs. — mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Mack

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Annie Wiegand

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Wm L Buppert

(Address) 2111 W Fairmount Ave

15-

Filed..... 191.....

ROBERT B. KRAUTH
Registrar.

SEP 14 1917
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Sept 12, 1917, that I saw her alive on Sept 12, 1917, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration)....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions of Labor

(Duration)....yrs....mos....ds.

(Signed) E. F. Dickey M. D.

Sept. 13, 1917. (Address) 141 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL, Sept 15 1917

20-UNDERTAKER Geo. A. Gerber

ADDRESS Balto Hayward

95

5

READ. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D 8157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S Mount ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo Gillen

(Residence in Baltimore: No. 217 So. Mount St.; 2 yrs., 16 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June 29, 1917 (Month) (Day) (Year)

7-AGE, 2 yrs. 16 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos. F. Gillen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Annie R. Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. F. Gillen

(Address) 217 So. Mount

15-

Filed SEP 14 1917, 191.. ROBERT A. KRAUTH Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1917, to Sept 14 1917, that I saw h[illegible] alive on Sept 13 1917, and that death occurred, on the date stated above, at 1.15a m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. 1 mos. ds.

(Signed) Wm O'Neill M. D.

Sept. 14, 191.. (Address) 108 N Bullitt ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Sept 16, 191..

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bulto St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8152

CERTIFICATE OF DEATH.

THIS IS A PERMANENT RECORD
INK should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Light St. St. 24 WARD) REGISTERED NO. C 28

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E. Cunningham

(Residence in Baltimore: No. 1033 Light St St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1899 (Year)

7-AGE,	If LESS than 1 day,
18 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Louis F. Cunningham

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Bridget Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bridget Cunningham

(Address) 1033 Light St

15-

SEP 11 1917

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 12 1917, that I saw h[illegible] alive on Sept 12 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

....., 191... (Address) 916 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Sept 15, 1917.

20-UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8153 — 104 — D 8153

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Loane

(Residence in Baltimore: No. 1037 Harford Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. January 6, 1917. (Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Loane

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Alice Frederick

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Loane

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14, 1917. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from September 6 1917, to September 14 1917, that I saw h[illegible] alive on September 14 1917, and that death occurred, on the date stated above, at 5-10a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis intestines

Tuberculosis pleura

.....

..... (Duration) .....yrs. 1 mos. .....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

Sept 14, 1917. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1037 Harford Ave

19-PLACE OF BURIAL OR REMOVAL, Bel Pedemer Cemy

DATE OF BURIAL, Sept 16, 1917

20-UNDERTAKER Henry Hirsch Sons

ADDRESS 1301 E Eager St

IMPORTANT—THIS IS A PERMANENT RECORD
WRITE WITH INDELIBLE INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 8451

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 572 Greystone ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Causby

(Residence in Baltimore: No. 572 Presstman St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 7, 1880
(Month) (Day) (Year)

7-AGE, 37 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Wife.
(b) General nature of industry, business, or establishment in which employed (or employer) 637

9-BIRTHPLACE, (State or Country) Prince George Co. Va.

PARENTS.

10-NAME OF FATHER, Anthony Allen

11-BIRTHPLACE OF FATHER (State or Country) Prince George Co Va

12-MAIDEN NAME OF MOTHER Charlotte Tyler.

13-BIRTHPLACE OF MOTHER (State or Country) Prince George Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm M Causby

(Address) 572 Presstman St Balto

15-

Filed SEP 15 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 191 7, to Sept 12 191 7.
that I saw her alive on Sept 12 191 7.
and that death occurred, on the date stated above, at 11.45 a.m.
The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Aortic Incompetency
(Duration) yrs. mos. 1½ ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
Asthenia (Duration) yrs. 6 mos. ds.

(Signed) Wm H. Wright M. D.
Sept 14 1917. (Address) 1209 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arlington Va — DATE OF BURIAL, Sept 14, 1917.

20-UNDERTAKER Groh Holland — ADDRESS 1631 F St

NOTE.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yaakie Gordon

(Residence in Baltimore: No. 741 S Eutaw Ave St.; (yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, December 3, 1910
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Amon Gordon

11-BIRTHPLACE OF FATHER (State or Country), Fla.

12-MAIDEN NAME OF MOTHER Annie Freeman

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Johns Hopkins Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 13 1917, that I saw h[illegible] alive on September 13 1917, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion
Acute

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Sept 13, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State Life ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 741 S Eutaw St

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Sept 15, 1917.

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Fleet St

SEP 15 1917

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 1047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeth Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Burgos

(Residence in Baltimore: No. St Elizabeth Home Cleveland & 38th Sts St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F'male	Color-	S

6-DATE OF BIRTH, June (Month) 20 (Day), 1917 (Year)

7-AGE, ... yrs. 2 mos. 19 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 1917 , that I saw h alive on Aug. 30th 1917 , and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldberg M. D.

9/14, 1917. (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

SEP 13 1917 JOHNS HOPKINS HOSPITAL

Commissioner Health.

NB: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—USE INDELIBLE INK

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Ellamont ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Flynn

(Residence in Baltimore: No. 2500 Ellamont St.; ~ yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Oakwood (Month) (Day), 1845 (Year)

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Bryan Flynn

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Kinnet

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard J. Flynn

(Address) 2500 Ellamont

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12 (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 12 1917, to Sept 12 1917, that I saw h— alive on Sept 12 1917, and that death occurred, on the date stated above, at 1155 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Cancer (?)

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cer. Intoxication

(Duration) yrs. mos. 6 ds.

(Signed) E V Cornelius M. D.

9/14/17, 191... (Address) 22 N Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Sept. 15th 1917

20-UNDERTAKER F. A. Krause — ADDRESS 705 Hanover

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH PERMANENT INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 8158

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Wolfe ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katharyn Schlerd

(Residence in Baltimore: No. 18 N. Wolfe St.; 82 yrs., 7 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Feb. (Month) 8 (Day), 1835 (Year)

7-AGE, 82 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, John Rodecker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Susan Smith

(Address) 1913 E. Lombard

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 13 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from May 26 1917, to Sept 13 1917, that I saw h Ex alive on Sept 12 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 3 mos. ds.

(Signed) Edward Glover M. D.

9/13, 1917. (Address) 413 Washington Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept. 15, 1917

20-UNDERTAKER Jos. J. Kerr — ADDRESS 156 N. Luzerne

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8459

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~30~~ 3008 Westwood Ave St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Phillips

(Residence in Baltimore: No. 3008 Westwood Ave, St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~Married,~~ WIDOWED, ~~OR DIVORCED~~ (Write the word.) Widowed

6-DATE OF BIRTH, Sept. (Month) 15 (Day), 1841 (Year)

7-AGE, 76 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Insurance Agt

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Thomas Phillips

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Nancy Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Henderson,

(Address) 3008 Westwood Ave

15-

Filed....., 191.....

Registrar.

SEP 15 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1917, to Sept 14 1917, that I saw h.. alive on Sept 12 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Left Side of Face

(Duration) 3 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas A Cary M. D.

....., 191... (Address) 101 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Sept. 15, 1917

20-UNDERTAKER George J. Smith

ADDRESS 1000 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 10476 8460

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 St. Anns ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Ewell.

(Residence in Baltimore: No. 614 St. Ann ave St.; ...yrs., 4 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... May (Month) 6 (Day), 1913 (Year)

7-AGE, ... yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Ewell.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Florence Shutlly.

13-BIRTHPLACE OF MOTHER (State or Country), Balto - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Anna M. Ward

(Address) 2032 Mad. Ave.

15-

SEP 15 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1917, to Sept 13, 1917, that I saw her alive on Sept 13 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert J. Green M. D.

Sept 14., 1917. (Address) 1120½ Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Cem

DATE OF BURIAL, Sept 17., 191.7

20-UNDERTAKER Wm Cook

ADDRESS 502 E. North

Dr Green 120 N Aisquith St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state

information should be carefully supplied.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Columbia Ave ST.: 21 WARD)

REGISTERED NO. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Osteud H. Peddicord

(Residence in Baltimore: No. 1716 Columbia Ave St.; 76 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Jan 9, 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ast Treas
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Garret Peddicord

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances A Peddicord

(Address) 1716 Columbia Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10. 191 , to Sept 14 191 , that I saw h alive on Sept 13 191 , and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cardiac Exhaustion

..... (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) 3 yrs. 6 mos. ds.

(Signed) Henry Barton M. D.

Sept 14, 191 7 (Address) 1716 Columbia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 16, 1917

20-UNDERTAKER Will Cook

ADDRESS 402 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8462 — 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 n Eden ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J Smith

(Residence in Baltimore: No. 436 n Eden St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Unkn — (Month), (Day), 1 (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Washington, D.C.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bellzura Smith

(Address) 436 N Eden St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1917, to Sept 13 1917, that I saw h in alive on Sept 12 1917, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Asthma

(Secondary) 2 months (Duration) yrs. 2 mos. ds.

(Signed) Edward Fisher M. D.

Sept 13 1917. (Address) 1612 E monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury cemetery. Sept 17, 1917. DATE OF BURIAL,

20-UNDERTAKER Milton. Davis ADDRESS 413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8403 — D 8403 — +51

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Daughton

(Residence in Baltimore: No.) Mercy Hospital St.; — yrs., — mos. 3 hrs ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	white	Married

6-DATE OF BIRTH, Dec 2 (Month) (Day), 1889 (Year)

7-AGE, 27 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telephone Operator
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Benj. D. Loughton

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Rector

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp

(Address) Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14 1917, to Sept. 14 1917, that I saw her alive on Sept. 14 1917, and that death occurred, on the date stated above, at 3.40 m.

The CAUSE OF DEATH* was as follows:

Edema Marasmus

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre

(Duration) .... yrs. .... mos. .... ds.

(Signed) Chas. E. Arnold M. D.

Sept. 14 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. 3 mos. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? Va

Former or usual residence Jonesville, Md.

19-PLACE OF BURIAL OR REMOVAL, Forest Hill Md — DATE OF BURIAL, ..., 191.7

20-UNDERTAKER E. L. Kintz — ADDRESS Jonesville Md

NANNY C. ARLOW
SEP 15 1917

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8161

CERTIFICATE OF DEATH.

104 D 8161

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Clarkson ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Knott

(Residence in Baltimore: No. 1712 Clarkson St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Sing

6-DATE OF BIRTH, ...Nov. 11...., 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 10 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, J. Lee Knott

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Lena Rothwaxer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Knott

(Address) 1712 Clarkson St.

15-

SEP 15 1917 ROBERT B. KRAUTH

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Sept 13 1917, that I saw h[illegible] alive on Sept 13 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. 2 ds.

(Signed) R. E. Campbell M. D.

Sept 14 1917. (Address) 1624 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Sept 15., 1917.

20-UNDERTAKER J. Mc L. Ellwood Son — ADDRESS 1428 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state

Correction of information should be carefully supplied.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8165 — 130 — D 8165

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 509 S. Paca ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Birstonas

(Residence in Baltimore: No. 509 S. Paca St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	Single

6-DATE OF BIRTH: Aug. 13 (Month) (Day), 1900 (Year)

7-AGE: 17 yrs. 1 mos. ....ds. — If LESS than 1 day, ...hrs., or ....min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Lithuania

PARENTS

10-NAME OF FATHER: John Birstonas

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Ama Salder.

13-BIRTHPLACE OF MOTHER (State or country): Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Birstonas

(Address) 509 S. Paca St.

15-

Filed ....., 191.. — REGISTRAR

SEP 15 1917 ROBERT R. KRAUTH
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9, 1917, to, Sept 13 1917, that I saw h[illegible] alive on Sept. 13 1917, and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs 6 mos ....ds.

Contributory (SECONDARY): Chr. Osteomyelitis of femur

(Duration) 4 yrs ....mos. ....ds.

(Signed) John Antuca dowsky M. D.

Sept 14 1917 [Address] 629 Columbia av.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence: 509 S. Paca St.

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: Sept. 17. 1917

20-UNDERTAKER: John Eichenlaub — ADDRESS: 425. S. Paca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D ñ 8166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 ñ 8166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.: 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Kenny.

(Residence in Baltimore: No. 702 St Peters St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. June (Month) 22 (Day), 1861 (Year)

7-AGE. 56 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Michael Burns

11-BIRTHPLACE OF FATHER (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER Mary Shaudy

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Lennon & Son

(Address) 1102 Pine St.

15-

Filed....., 191.....

SEP 15 1917 ROBERT R. KRAUTH Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 13 1917, that I saw her alive on Sept 13 1917, and that death occurred, on the date stated above, at 4 1/2 a m.

The CAUSE OF DEATH* was as follows:

(a) Coma Pneumonia

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. B. Brumbaugh M. D.

Sept. 13 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 702 St. Peters St.

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Sept. 15 1917

20-UNDERTAKER. James Dignan & Son

ADDRESS 1000 S Paca St

CAUSE OF DEATH. THIS IS A PERMANENT RECORD
All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Theodore Hinrichs

(Residence in Baltimore: No. Hotel Rennert. St.; 4/2 yrs., mos. ds.)

THIS IS A PERMANENT RECORD

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important information should be carefully supplied. AGE should be stated IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Aug. 27th (Month) (Day), 1856 (Year)

7-AGE, 61 yrs. mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): (625)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry W. Hinrichs

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Doris Beugen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arnold W. Orrell

(Address) Hendale & Guyon Oakes

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9th 1917, to Sept 14th 1917, that I saw h alive on Sept 14th 1917, and that death occurred, on the date stated above, at 2.40 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. C. Childs M. D.

Sept 14th, 1917. (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 16 1917
20-UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 8168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Pearson

(Residence in Baltimore: No. 1110 N. Fayette St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 3 (Day), 1853 (Year)

7-AGE, 64 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Peebuyer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. L. Pearson

(Address) 1110 N. Fayette St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 7 191 7, to Sept 14 191 7, that I saw h.. alive on Sept. 14 191 7, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

a. Chronic interstitial Nephritis

(Antecedent Causes)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) ....yrs. 2 mos. ....ds.

(Signed) Chas E Fouch M. D.

Sept 17, 1917. (Address) 621 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 6 mos. 7 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Baltimore

Former or usual residence 1110 N Fayette St

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, Sept 17, 1917.

20-UNDERTAKER Chas E Fouch — ADDRESS 621 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8469

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 8469

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkin Hospital St.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dellenie

(Residence in Baltimore: No. 1914 Mc Kean Ave. St.; ....yrs., ...mos. ....ds.)

THIS IS A PERMANENT RECORD

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Correction of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 17, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tobacco dealer.
(b) General nature of Industry, business, or establishment in which employed (or employer) 645

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Dellenie

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Henrietta Priebman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Phelps

(Address) Johns Hopkin Hosp.

15-

Filed....., 191.....

ROBERT R. KRAUTH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1917, to Sept 14 1917, that I saw h in alive on Sept 14 1917, and that death occurred, on the date stated above, at 11½ a. m.

The CAUSE OF DEATH* was as follows:

(a) Diabetes Mellitus

(Duration) 15 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy

(Duration) 10 yrs. ....mos. ....ds.

(Signed) J. E. Howard Barnes M. D.

Sept 14, 191 7 (Address) Johns Hopkin Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 7 ds. In the State yrs. — mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1914 Mc Kean Ave.

19-PLACE OF BURIAL OR REMOVAL, Har Sinai Cem. DATE OF BURIAL, Sept. 16, 191 7.

20-UNDERTAKER David Sondheim ADDRESS 118 W. Lexington Ave

Form —5-19-15—M. & T.—500 Bks.

D 8470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 D 8470

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N. Fremont ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J. Finch

(Residence in Baltimore: No. 807 N. Fremont St.) 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem.

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, Feby 4, 1880 (Month) (Day) (Year)

7-AGE, 37 yrs. 7 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Jas. R. Hunt

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Martha A. Fitzgerald

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. R. Finch (husband)

(Address) 807 N. Fremont

15-

Filed SEP 15 1917 191 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about a year ~~last~~ to Sept 15 1917, that I saw her alive on Sept 14 1917, and that death occurred, on the date stated above, at 1:50 a.m.

The CAUSE OF DEATH* was as follows:

Heart failure and
oedema of lungs

(Duration) yrs. mos. 5 ds. 6

CONTRIBUTORY (Secondary) Paralysis

(Duration) about 1 yr. mos. ds.

(Signed) F. C. Turnbull M. D.

Sept. 15 1917 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem

DATE OF BURIAL: Sept. 17, 1917

20-UNDERTAKER: Geo. J. Smith

ADDRESS: 1000 N Payette

IMPORTANT.—This is a PERMANENT RECORD. Accuracy of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8171 — 138 — D 8171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. University Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen J. McCleca

(Residence in Baltimore: No. 615 Lombard St St.; yrs., mos. ds.)

THIS IS A PERMANENT RECORD

CAUSE of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1881 (Year)

7-AGE, 36 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: H. W.
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Greece

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Brown

(Address) Calhoun & Fulton

15- SEP 15 1917 ROBERT R. KRAUTER SUPT. VITAL STATISTICS

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 15 1917, that I saw h[illegible] alive on Sept. 15 1917, and that death occurred, on the date stated above, at 6.20 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion from Cholera

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) I. Mark C. Marcus M. D.

Sept. 15, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. 2 mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 512 W. Balt. St.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. — DATE OF BURIAL, Sept. 16, 1917.

20-UNDERTAKER Robert Brown — ADDRESS Calhoun & Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 5 WARD)

REGISTERED NO. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Fetsch.

(Residence in Baltimore: No. 600 Enson St St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD. All of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, February 12, 1915
(Month) (Day) (Year)

7-AGE, 2 yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nicholas Fetsch

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Dora Preu

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Fetsch

(Address) Johns Hopkins Hosp.

15-

Filed SEP 15 1917, 191.....

ROBERT E. KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1917, to Sept 14 1917, that I saw h[illegible] alive on Sept 14 1917, and that death occurred, on the date stated above, at 2 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebellar tumor.

(Duration) ..... yrs. 1 1/2 mos. ..... ds.

CONTRIBUTORY (Secondary) Operation on tumor

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. M. Rowan M. D.

Sept. 14, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 49 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 600 Enson St

19-PLACE OF BURIAL OR REMOVAL, Baltimore City — DATE OF BURIAL, Sept 17, 191..

20-UNDERTAKER Chas. Deuner — ADDRESS 1442 21 Pkwy

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8473 — 154 — D 8473

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1108 Woodyear St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Mr & Mrs Otis Hayes

(Residence in Baltimore: No. 1108 Woodyear St — St.; ... yrs., ... mos. ... ds.)

THIS IS A PERMANENT RECORD

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Infant

6-DATE OF BIRTH, Sept 14, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, 8 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Premature
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Otis Hayes

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Otis Hayes

(Address) 1108 Woodyear

15- SEP 15 1917

Filed ..., 191... ROBERT R. KRAUTER Registrar.

Daniel Fermis Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ... 191 ..., to ... 191 ...,

that I saw her alive on Sept 14 — 191 7,

and that death occurred, on the date stated above, at 4:35 p m.

The CAUSE OF DEATH* was as follows:

Premature birth

6 days Child

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ...
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Tillerson M. D.

Sept 15, 191 7 (Address) 1131 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Sept 16, 1917

20-UNDERTAKER Parran & Doughty

ADDRESS 1364 W Lanvale

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Louise Warner

(Residence in Baltimore: No. In Hospital St.; ..... yrs., ... mos. 4 ds.)

CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, September 23, 1915
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 22 ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER Clarence A. Warner

11-BIRTHPLACE OF FATHER (State or Country), B Va

12-MAIDEN NAME OF MOTHER Mary Schadty

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence A. Warner

(Address) 3616 E Lombard St

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 191.., to Sept 14 191..,
that I saw her alive on Sept 14 191..,
and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Cerebro-Spinal
Meningitis

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B. Conrad M. D.

9-14..., 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 3616 E Lombard St

Former or usual residence 3616 E Lombard St

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery | DATE OF BURIAL, Sept 15, 1917

20-UNDERTAKER Konstantin Muller | ADDRESS 2334 Jefferson

Mary Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 130

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1707 Ditman et 16 ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Johnson

(Residence in Baltimore: No. 1707 Ditman et St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, October, 1875.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 021

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) 1707 Ditman Ct

15- SEP 15 1917

Filed ....., 191.....

ROBERT B. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Cerebral Hemorrhage
2. Ulcer
3. Ulcer
(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Unknown
(Duration) yrs. mos. ds.

(Signed) Wm H Holtzclaw
(Coroner) M. D.

Sept 14, 1917. (Address) 19 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 70 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion — DATE OF BURIAL, Sept. 16, 1917

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 N Caroline

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

PRINT PLAINLY—USE INDELIBLE INK—THIS IS A PERMANENT RECORD

Information should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 8176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 E. Biddle ST.: 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily J Colwell

(Residence in Baltimore: No. 616 E Biddle St.: 64 yrs., mos. ds.)

THIS IS A PERMANENT RECORD

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. October (Month) 13 (Day), 1853 (Year)

7-AGE. 63 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

8 0 0 0 0

9-BIRTHPLACE, (State or Country). Carroll Co. Md.

PARENTS.

10-NAME OF FATHER. Hanson Franklin

11-BIRTHPLACE OF FATHER (State or Country). Carroll Co Md.

12-MAIDEN NAME OF MOTHER Ruth Welsh

13-BIRTHPLACE OF MOTHER (State or Country). Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell Colwell

(Address) 616 E Biddle St

15-

Filed....., 191.... ROBERT B. KRAUTER Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 14 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 14 1917, that I saw her alive on Sept 13 1917. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Gall Stones (Duration) 1 yrs. mos. ds.

(Signed) James M Kerlin M. D.

Sept 14 1917 (Address) 702 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Morgan Chapel Carroll Co Md

DATE OF BURIAL. Sept 16, 1917

20-UNDERTAKER Wm Cook

ADDRESS 602 E. Mon

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8177

81 ✓

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 2027 Mura St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wesley Murphy

(Residence in Baltimore: No. 2027 Mura St; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) Unknown, (Day) 1 (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of Industry, business, or establishment in which employed (or employer): Helper 031

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sarah Price

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo. Baumgartner

(Address) 2027 Mura St

15-

Filed SEP 15 1917, 191.... ROBERT B. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 14 1917, that I saw h[im] alive on Sept 14 1917, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Several years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 7 ds.

(Signed) Walter Worthington M. D.

Sept 15, 1917 (Address) 1101 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's

DATE OF BURIAL, Sept 17, 1917

20-UNDERTAKER A. S. Marshall

ADDRESS 3539 Gaud Rd

Study form of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

311

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1715 St James ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Osmond Simms

(Residence in Baltimore: No. 1715 St. James St.; ...yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: June (Month) 15 (Day) 1916 (Year)

7-AGE: 1 yrs. 2 mos. ... ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): Balto City

PARENTS

10-NAME OF FATHER: John Simms

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Carrie Burton

13-BIRTHPLACE OF MOTHER (State or country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Burton

(Address) 1710 St James

15-

Filed SEP 16 1917 191...

ROBERT R. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 14th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13th, 191..., to, Sept 14th, 191...,
that I saw h... alive on Sept 13th, 191...,
and that death occurred, on the date stated above, at 1:30 m.
The CAUSE OF DEATH* was as follows:

Tacho Cardiac Collapse

(Duration) ... yrs. ... mos. 2 ds.

Contributory (SECONDARY) Pneumonia

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. D. Stone M. D.

Sept 15th, 191... [Address] 1501 E Baltimore

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ...yrs ...mos ...ds. In the State ...yrs ...mos ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Lutheran Cemetary

DATE OF BURIAL: 9-17-17 191...

20-UNDERTAKER: Wm R A Elliott

ADDRESS: 506 East Pl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

INK—THIS IS A PERMANENT RECORD

D 8179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St.) WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH,
..... (Month) ..... (Day) ..... (Year)

7-AGE,
..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191.. ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
..... (Month) ..... (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	....., 19..
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

—THIS IS A PERMANENT RECORD

—USE INDELIBLE INK—

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8180 — 45 — D 8180

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 924 McCulloh ST. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Cassell

(Residence in Baltimore: No. 924 McCulloh St. 17 yrs. 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: March (Month) ..... (Day), 1900 (Year)

7-AGE: 17 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Herman Cassell

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Rachel Lena Seigel

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Lewis

(Address) 1411 E Balto St

15- Filed SEP 16 1917, 191 ..... ROBERT B. CRAWFORD Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24, 1917, to Sept 15 1917, that I saw h[illegible] alive on Sept 14, 1917, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Carcoma of Lungs & Kidney

..... (Duration) ..... yrs. 6 mos. — ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno D Blake M. D.

Sept 16, 1917. (Address) 1014 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Wash Road — DATE OF BURIAL: 9/16, 1917

20-UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonia Stanek

(Residence in Baltimore: No. 805 N. Chester St.; 22 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Not Known (Month) (Day) 1890 (Year)

7-AGE, 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) Home Sewing

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Stanek

11-BIRTHPLACE OF FATHER (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER Mary Korban

13-BIRTHPLACE OF MOTHER (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stanek

(Address) 805 N. Chester st.

15-

Filed ....., 191.... SEP 16 1917 ROBERT B. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13th, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 1st, 1917, to September 13th, 1917, that I saw her alive on September 12th, 1917, and that death occurred, on the date stated above, at 5:15 p. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY Tuberculosis of Vulva ext.
(Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) Wm. H. A. Mc Ey M. D.

Sept. 15th, 1917 (Address) 1034 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 16th, 1917

20-UNDERTAKER Frank Brack & Son — ADDRESS 1111 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8182 — 104

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 721 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo Radzia Skutnik

(Residence in Baltimore: No. 721 S. Ann St.; ...yrs., 3 mos. 18 ds.)

THIS IS A PERMANENT RECORD. CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, May (Month) 27 (Day), 1917 (Year)

7-AGE, ...yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Rock Skutnik

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Jessie Zwolinska

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rock Skutnik

(Address) 721 S. Ann St.

15- SEP 16 1917 ROBERT B. KRAUTER Registrar.
Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1917, to September 10 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) Indigestion

(Duration) ...yrs. 2 mos. ...ds.

(Signed) H. Emanuel Klein M. D.

Sept. 16, 1917. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loby Rosary — DATE OF BURIAL, Sept 17, 191...

20-UNDERTAKER: Wm. Kaufmann's — ADDRESS: 1618 Eastern

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

Deucke

172

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1344 N Bond St.; WARD)

2-FULL NAME Christopher J. A. Deucke

(Residence in Baltimore: No. 1344 N. Bond St.; yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: August (Month) 1 (Day), 1844 (Year)

7-AGE: 76 yrs. 1 mos. 13 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Baker

003

9-BIRTHPLACE (State or country): Erfurt Germany

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) John Deucke

(Address) 134 N. Bond

15-

Filed ..... 191 ..... Registrar

SEP 16 1917

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 1917, to, Sept 13 1917, that I saw h.. alive on Sept 13 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 11 ds.

Contributory (SECONDARY) Accidently fell Striking Rear Head on Radiator Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 11 ds.

(Signed) John Deucke M. D.

Sept 15, 191 7 [Address] 9365 Monument St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Sept 16, 1917

20-UNDERTAKER: Harry H. Witzke

ADDRESS: 1514 W Lombard St

D. Smith
Lytt st.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8181 — 92 — D 8181

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 406 Grindall st ST: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence D Harrell Jr

(Residence in Baltimore: No. 406 Grindall St.: yrs. 5 mos. 8 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Sngl

6 DATE OF BIRTH: April (Month) 7 (Day), 1911 (Year)

7 AGE: yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Clarence D. Harrell

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Dressel

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence D. Harrell

(Address) 406 Grindell st

15 Filed , 191 REGISTRAR

SEP 16 1917 ROBERT R. KRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 15 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1917, to Sept 15 1917.

that I saw him alive on Sept 15, 1917.

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) F. Edw Lynch M. D.

9/15, 191 (Address) 910 Light st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cmdy

DATE OF BURIAL: 9-17, 191 7

20 UNDERTAKER: H E Tulley

ADDRESS: 2703 Edmondson Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8185

H 7 D 8187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Mathews

(Residence in Baltimore: No. 621 Mulberry St. St.; 43 yrs., 6 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 1st, 1874 (Month) (Day) (Year)

7-AGE 43 yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter 086
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Bargain House

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas Mathews

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hosp Data

(Address) Green & Lombard

15-

Filed....., 191....

Registrar.

SEP 16 1917 ROBERT B. KRAUTER CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1917, to Sept 13 1917, that I saw him alive on Sept 13 1917, and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum with tumor Cachexia

Duration 3 mos.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) C Reifschneider M. D.

9/14, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos 24 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? 621 Mulberry St

Former or usual residence 621 Mulberry St

19-PLACE OF BURIAL OR REMOVAL, Harmans Md. DATE OF BURIAL, Sept. 16 1917

20-UNDERTAKER John M. Johnson ADDRESS 1234 Etting Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D 8486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8486

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Rickenmann

(Residence in Baltimore: No. 109 S Bond St St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state how disease originated, whether primary, secondary or complicating, and how long each existed. Indefinite terms, such as "debility," "old age," "exhaustion," "general peritonitis," "septicæmia," "pyæmia," "uræmia," "convulsions," "apoplexy," "paralysis," "tumor," "cancer," "abscess," "inflammation," "fever," "hemorrhage," "dropsy," "heart disease," "lung disease," "kidney disease," "liver disease," "stomach disease," "bowel disease," "childbirth," "miscarriage," "accident," "suicide," "homicide," should not be used unless absolutely necessary, and then only when explained by a statement of the cause of each. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 6, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Rickenmann

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Martin

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15- SEP 16 1917 ROBERT R. CRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 12 1917, to Sept 15 1917, that I saw h[illegible] alive on September 15 1917, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion, acute.

.....

.....

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Conrad M. D.

Sept. 15, 191.. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 109 S Bond St

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Sept. 16, 1917.

20-UNDERTAKER Tilly & Keiler ADDRESS 413 N. Gilmor St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8157

CERTIFICATE OF DEATH.

104 D 8157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2618 Fair Ave ST.; 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona Weber

(Residence in Baltimore: No. 2618 Fair Ave. St.; ..yrs. 10 mos. ..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ..Nov. (Month) 16 (Day), 1916 (Year)

7-AGE, ..yrs. 9 mos. 28 ds. If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Louis B. Weber

11-BIRTHPLACE OF FATHER (State or Country), Mich.

12-MAIDEN NAME OF MOTHER Agnes Wisniewski

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis B. Weber

(Address) 2618 Fair Ave

15-

Filed SEP 16 1917, 191.. ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 14 1917, that I saw h.. alive on Sept 13 1917, and that death occurred, on the date stated above, at 11½ p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ..yrs. 2d mos. ..ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) ..yrs. ..mos. ..ds.

(Signed) [illegible] M. D.

Sept 16, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus — DATE OF BURIAL, Sept. 16, 1917

20-UNDERTAKER Stephen J. Fialkowski — ADDRESS 1017 S. Kenwood Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. THIS IS A PERMANENT RECORD it may be properly classified. Exact statement of OCCUPATION is very

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8485

CERTIFICATE OF DEATH

D 8488

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2034 W Saratoga St. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice C. Posey

(Residence in Baltimore: No. 2034 W Saratoga St.: yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PRINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: 2 (Month) 2 (Day), 1835 (Year)

7-AGE: 82 yrs. 7 mos. 12 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: Jas. D. Moran

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Musgrove

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Graves.

(Address) 2034 W Saratoga St

15

Filed SEP 16 1917, 191 ROBERT B. KRAUTER REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 14th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1917, to Sept 13 1917, that I saw h[illegible] alive on Sept 16th 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterial Debility

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Benj. Dr Leary M. D.

Sept 16, 1917. (Address) 400 N Bryson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mechanicsville Md | DATE OF BURIAL: Sept 17 1917.

20-UNDERTAKER: Geo. A. Gatch | ADDRESS: Balto Bryson 52.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8489

CERTIFICATE OF DEATH.

D 8489

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 W. Lafayette ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Selma Gripf

(Residence in Baltimore: No. 1404 W. Lafayette St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 21, 1915
(Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Carl Gripf

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Rosta Young

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L Gripf

(Address) 1404 W. W. Lafayette

15-

Filed SEP 16 1917, 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Sept 15 1917, that I saw her alive on Sept 14 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 1½ ds.

CONTRIBUTORY (Secondary) Carbuncle

(Duration) ....yrs. ....mos. 1 ds.

(Signed) E. W. Carbaugh M. D.

Sept 16, 1917. (Address) 24 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 17, 1917.

20-UNDERTAKER John J. Fields

ADDRESS 1200 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8490

CERTIFICATE OF DEATH.

D. 8490

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Corbett - Twin

(Residence in Baltimore: No. 1424 Gough Street. St.; .....yrs., mos. ds.)

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH. September 7, 1917.
(Month) (Day) (Year)

7-AGE. .....yrs. .....mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Joseph Corbett.

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rae Marcus

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Murray Jr. M.D.

(Address).....

15-

Filed SEP 10 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Sept 10 1917, that I saw her alive on Sept 10 1917 and that death occurred, on the date stated above, at 2.10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Hydramnios - Single Born Twins -

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration).....yrs.....mos. 3 ds.

(Signed) John G. Murray Jr. M. D.

Sept 11, 1917. (Address) John Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 3 mos. 3 ds. In the State ....yrs. 3 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1424 Gough Street

19-PLACE OF BURIAL OR REMOVAL, Hebrew Nat. Farmd DATE OF BURIAL, Sept. 11 1917.

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8491

D 8491

CERTIFICATE OF DEATH.

REGISTERED No. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 N. Patterson Park Av ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie A. Dailey

(Residence in Baltimore: No. 800 N Patterson Park Av St.; ...yrs.,...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov 11, 1848
(Month) (Day) (Year)

7-AGE, 68 yrs. 10 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Rudeloff

11-BIRTHPLACE OF FATHER (State or Country), Germ.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Moorhouse

(Address) 1603 N. Broadway

15-

Filed SEP 16 1917, 191.. ROBERT P. STAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1917, to Sept 13 1917, that I saw h[er] alive on Sept 13 1917, and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ...yrs. ...mos. 2 ds.

(Signed) Geo E Blade M. D.

9/15, 191.7 (Address) 1436 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Baltimore Cem	Sept 17 191.7
20-UNDERTAKER	**ADDRESS**
Albert E Hudle	221 N Brady

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8492

CERTIFICATE OF DEATH.

104 D 8492

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkin Hosp. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew German

(Residence in Baltimore: No. 146 Irving St. Irvington St.; yrs., mos. ds.)

Irving St

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Child

6-DATE OF BIRTH, July (Month) 24 (Day), 1917 (Year).

7-AGE, ...yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Andrew German

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lottie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. T. Sibley

(Address) Johns Hopkins Hosp.

15- SEP 16 1917

Filed ....., 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 15 1917, that I saw him alive on Sept 15 1917, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Indigestion, Acute

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Double Lobar Pneumonia, Chronic Abscess (Duration) ....yrs. ....mos. 7 1 ds.

(Signed) J. M. Rivers M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. 5 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 146 Irving St Irvington Md.

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Sept 18th 1917.

20-UNDERTAKER Chas. H. Dill ADDRESS 3109 Freeth Ave.

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state all information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D 8493

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 D 8493

REGISTERED NO. C.....

1 PLACE OF DEATH

Robert Garrett Hospital

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madaline Letrshet

(Residence in Baltimore: No. 18 South Arlington Ave St.; ..... yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: July 21, 1917 (Month) (Day) (Year)

7-AGE: — yrs. 1 mos. 25 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10-NAME OF FATHER: B William Smith

11-BIRTHPLACE OF FATHER (State or country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Margaret Letrshet

13-BIRTHPLACE OF MOTHER (State or country): South River, N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Letrshet

(Address) 615 N Lafayette ave

15- SEP 16 1917 ROBERT B. KRAUTER

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5, 1917, to, September 15 1917, that I saw her alive on September 15 1917, and that death occurred, on the date stated above, at 3.40 p.m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) — yrs — mos. 28 ds.

Contributory (SECONDARY) Marasmus

(Duration) — yrs 2½ mos. — ds.

(Signed) John O Sloek M. D.

Sept 15, 1917 [Address] 27 W. Carey St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos 10 ds. In the State — yr 2 mos — ds.

Where was disease contracted, If not at place of death? Aberdeen, Md

Former or usual residence Baltimore, Md

19-PLACE OF BURIAL OR REMOVAL: Harmony Salem — DATE OF BURIAL: Sept 17, 191 7

20-UNDERTAKER: David Easter — ADDRESS 916 Penna ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8492

CERTIFICATE OF DEATH.

40 D 8492

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1620 E. 6 Clement ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta J. Wilhelm

(Residence in Baltimore: No. 1620 E. 6 Clement St.; 4 yrs., 3 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Apr. (Month) ..... 1 (Day) ....., 1913 (Year)

7-AGE, ...4.... yrs. ...3.... mos. ...14.... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Adolph Wilhelm

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Augusta Kuster

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Adolph Wilhelm.....

(Address).....1620 E. 6 Clement

15- SEP 16 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... September (Month) ..... 15 (Day) ....., 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1917, to Sept 15 1917, that I saw h.. alive on Sept 14 1917, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

Clinical (Duration).....yrs. 2 mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

7/16....., 1917. (Address)...1220 Linden Ave.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, 9/17, 1917.

20-UNDERTAKER J. Frew McCully

ADDRESS 131 E. Fort.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 8495

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 Bruce St. (Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances A. Gardner

(Residence in Baltimore: No.) 720 Bruce St. St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 1st, 1852
(Month) (Day) (Year)

7-AGE. 65 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, John Shipley

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Emily Manning

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Gardner

(Address) 720 Bruce St

15-

SEP 16 1917

Filed....., 191.... ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1917, to Sept 15 1917, that I saw her alive on Sept 15 1917, and that death occurred, on the date stated above, at 8.50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) Geo. Wheeler M. D.

Sept 15, 1917. (Address) 600 Harlem Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, Sept 17, 1917

20-UNDERTAKER Robt S. Little — ADDRESS 531 N Fremont Ave

Burial Permit Issued

THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8496

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barney Redding

(Residence in Baltimore: No. 1432 N. McHenry St. St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 8, 1890
(Month) (Day) (Year)

7-AGE, 26 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Don't know.

11-BIRTHPLACE OF FATHER (State or Country), Don't know

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Redding

(Address) 1432 N. McHenry St.

15-

Filed Sept 7 1917, 191.... HARRY C. ANDREWS Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/11 1917, to 9/15 1917, that I saw h alive on 9/15 1917, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 8 days

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. McHenry M. D.

9/15, 191.. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. 6 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1432 N. McHenry St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Sept 17, 191..

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. North

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

234

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8497

D 8497

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Sargent St. 10 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Cramer

(Residence in Baltimore: No. 1104 Sargent St St.; ..... yrs., 7 mos. 22 ds.)

THIS STATEMENT RECORD

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Jan. (Month) 24 (Day), 1837 (Year)

7-AGE, 80 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Clerk

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Daniel Cramer

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Borgel

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alta E. Bailey

(Address) 1104 Sargent St

15- HARRY C. ANDREWS

Filed ....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1917, to Sept 15 1917, that I saw him alive on Sept 14 1917, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Anasarca

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Lamprecht M. D.

Sept. 15, 191 7. (Address) 826 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept. 17, 1917

20-UNDERTAKER Wm Leach

ADDRESS 407 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8298

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8298

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeth Home, ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Linwood Meredith

(Residence in Baltimore: No. St Elizabeth Home St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 29, 1912
(Month) (Day) (Year)

7-AGE, 5 yrs. 15 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Meridith

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Mother Mildred

(Address) St. Elizabeth Home

15-

Filed SEP 17 1917, 191.... HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10 191 , to Sept 13 191 , that I saw h in alive on Sept. 12 191 , and that death occurred, on the date stated above, at a, m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. ds.

(Signed) Harry Goldberg M. D.

9/16, 191.7 (Address) 2031 W Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. — mos. 15 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? St Elizabeths Home

Former or usual residence St Elizabeths Home

19-PLACE OF BURIAL OR REMOVAL, New Cathedral cty DATE OF BURIAL, Sept 17, 191.7.

20-UNDERTAKER J C H Holland ADDRESS 1631 E Hav

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8499

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Stewart

(Residence in Baltimore: No. In Hospital St.; — yrs., — mos. 8 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Child

6-DATE OF BIRTH, March (Month) 22 (Day), 1915 (Year)

7-AGE, 2 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Arthur Stewart

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Hook

13-BIRTHPLACE OF MOTHER (State or Country), W Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Dudley

(Address) Johns Hopkins Hosp.

15-

Filed SEP 17 1917, 191.....

HARRY C. ANDREWS
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 16 1917, that I saw her alive on Sept. 16 1917 and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Meningitis (Staphy. Lo. Co. Cus.) (Duration) ....yrs. ....mos. 1 ds.

(Signed) D. M. Rivers M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Jones Ave, Catonsville Md

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Western Star Cem Catonsville Md	Sept 19, 1917
20-UNDERTAKER Edw Pyc	ADDRESS Catonsville Md

D 8500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8500

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Carter

(Residence in Baltimore: No. Father's residence = 148 Hanover St ST.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, April 5, 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John F Carter

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Katharine O'Neill

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Walter

(Address) 1013 Hanover St

15-

SEP 1 1917 HARRY C. ANDREWS Registrar Eastern District

Filed....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congestion Lungs Kidneys and brain

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Operation Hernia

(Duration) yrs. mos. ds.

(Signed) W. S. Ritter M. D.
(Coroner.)

Sept 16, 1917. (Address) 1013 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 day yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Sept 17 1917

20-UNDERTAKER	ADDRESS
James Dynan & Son	1000 Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE WITH BLACK INK

Spec.—8-24-14—M. & T.—2000 Bks.

D 8501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8501

REGISTERED No. C 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Riddison Jr.

(Residence in Baltimore: No. 3014 Walbrook Ave. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 8, 1901
(Month) (Day) (Year)

7-AGE, 16 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ~~00~~

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, F. W. Riddison,

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hill

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank B. Matthew Riddison

(Address) 3014 Walbrook Ave.

15-

Filed SEP 17 1917, 191.. HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 16 1917, that I saw h. alive on Sept 16 1917, and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis (Perforated)

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Purulent

(Duration) ....yrs. ....mos. 7 ds.

(Signed) D. F. Taber M. D.

....., 191... (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State 16 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Home 3014 Walbrook Ave.

Former or usual residence 3014 Walbrook Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Sept 18, 1917
20-UNDERTAKER George J Smith	ADDRESS 1000 Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8502

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

D 8502

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No Methodist Home yrs aged St. 20 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William E. McCauley.

(Residence in Baltimore: No. Methodist Home for Aged St.; 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~ (Write the word): Widowed

6 DATE OF BIRTH: August 26 (Month) (Day), 1831 (Year)

7 AGE: 86 yrs. mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer): 214 Oil

9 BIRTHPLACE (State or country): Balto. Co. Md

PARENTS

10 NAME OF FATHER: Robert McCauley

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Parks

13 BIRTHPLACE OF MOTHER (State or country): Harford Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss E. R. Kemehan Supt

(Address) Methodist Home

15 HARRY C. ANDREWS

Filed SEP 17 1917, 191 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 15 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1917, to Sept 15 1917 that I saw him alive on Sept 14, 1917. and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Senile Debility

Cystitis Chronic, (Chronic Nephritis

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Complication of Diseases

(Duration) yrs. mos. ds.

(Signed) Esther Chrisman M. D.

Sept 15, 1917 (Address) 709 Harrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. mos. ds. In the City 84 yrs. mos. ds.

Where was disease contracted, if not at place of death? M E Home Baltimore City

Former or usual residence Brantford Ont

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Sept 17, 1917

20 UNDERTAKER: George J Smith

ADDRESS: Fayette W

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MUST BE WRITTEN WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8503 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 1320

CITY OF BALTIMORE: (No. S. W. Cor Franklin and Fulton ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Martha M^c Fadden

(Residence in Baltimore: No. Home for the Aged of the M E Church St.; — yrs., — mos. — ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. AGE should be carefully supplied. If OCCUPATION is very properly classified. Exact statement of OCCUPATION is very

PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 15 (Month) (Day), 1839 (Year)

7-AGE, 78 yrs. 8 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Harford Co Md.

PARENTS.

10-NAME OF FATHER, Charles F. McFadden

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Giles

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. P. Monahan

(Address) M. E. Home Fulton Ave

15-

Filed SEP 17 1917, 191...

HARRY G. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1917, to Sept 16 1917, that I saw h^r alive on Sept 14 1917, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Interstitial (Duration) 2 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis Acute

(Duration) 6 yrs. 2 mos. 6 ds.

(Signed) Geo B Shannon M. D.

Sept 17, 1917 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. mos. ds. In the State M E Home Pimlico & Franklin yrs. mos. ds.

Where was disease contracted, if not at place of death? At the Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rock Burial Ground Forest Md

DATE OF BURIAL, Sept 19, 1917.

20-UNDERTAKER George J Smith

ADDRESS Forest Md

Spec.—8-24-14—M. & T.—2000 Bks.

D 8504

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 8504

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Bradley

(Residence in Baltimore: No. 1825 Hanover St. St.; 53 yrs., 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH: Feb. (Month) 9 (Day), 1864 (Year)

7-AGE: 53 yrs. 7 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: John C. Bradley

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Hofnagel

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bradley

(Address) 1825 Hanover St.

15- SEP 17 1917

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1917, to Sept 15 1917, that I saw h alive on Sept 15 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Dysentery

Pulmonary Tuberculosis

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) .... yrs. 3 mos. .... ds.

(Signed) R. P. Campbell M. D.

Sept 17, 1917 (Address) 1624 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, 9/18, 1917

20-UNDERTAKER J. Few McCully

ADDRESS 130 E. Fort

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 8505

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 8505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irving Johnson.

(Residence in Baltimore: No. 1203 N Wolf St. St.: ~ yrs., ~ mos. ~ ds.)

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Child

6-DATE OF BIRTH, August (Month) 9 (Day), 1915 (Year)

7-AGE,	If LESS than 1 day,
2 yrs. 1 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Edward Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Milie Bordley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Sibley

(Address) Johns Hopkins Hosp.

15- SEP 17 1917 HARRY O. ANDREWS Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 16 1917, that I saw him alive on Sept 16 1917, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration)....yrs....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Harry B. Conrad M. D.

....., 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~ yrs. ~ mos. ~ ds. In the State ~ yrs. ~ mos. 1 ds.

Where was disease contracted, if not at place of death? ~

Former or usual residence 1203 Wolf St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept 19, 1917
20-UNDERTAKER Joseph A Farrell	ADDRESS, 1308 Division

Spec.—8-24-14—M. & T.—2000 Bks.

D 8506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkin Hosp. ST.; 3 WARD)

REGISTERED No. C 1041

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henery Ackerman

(Residence in Baltimore: No. 109 S. Bond St. St.; —yrs., —mos. —ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Space below reserved for information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, November (Month) 16 (Day), 1915 (Year)

7-AGE, 1 yrs. 9 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Ackerman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Mertens

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Sibley

(Address) Johns Hopkin Hosp.

15-

Filed SEP 17 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 15 1917, that I saw h[illegible] alive on Sept 15 1917, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Indigestion

Acute

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Conrad M. D.

191..., (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State yrs. Life ds.

Where was disease contracted, if not at place of death?

Former or usual residence 109 S. Bond St.

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Sept 17, 191 7.

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 E Wolfe St

D 8507. HEALTH DEPARTMENT—CITY OF BALTIMORE 119 D 8507.

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH 2874 W. Lanvale 16
CITY OF BALTIMORE (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Gotthey

(Residence in Baltimore: No. 2874 W. Lanvale St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan. 16, 1897
(Month) (Day) (Year)

7-AGE, ... 20 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)..... 273 Dry

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles E. Gotthey

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Freyer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Mansen

(Address) Baltimore Md

15-

Filed ....., 191.....
Registrar.

SEP 18 1917 HARRY D. ANDREWS CITY REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Acute Pulmonary Tuberculosis
.....
.....
..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Colds & Exposure
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

(Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Sept. 17, 1917
20-UNDERTAKER	ADDRESS
E. Schloman & Son	1039 Hanover St

N. B.—THIS IS A PERMANENT RECORD—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8503

HEALTH DEPARTMENT—CITY OF BALTIMORE

1/4 D 8508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Beatty.

(Residence in Baltimore: No. 1518 Mc Cullough St.; ? yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	married

6-DATE OF BIRTH, ? ? 1851
(Month) (Day) (Year)

7-AGE, 66 ? ? yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Keeping House
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, ? Geary

11-BIRTHPLACE OF FATHER (State or Country), Not known to family

12-MAIDEN NAME OF MOTHER Not known.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C/C Kelly M.D.

(Address) Union Prot. Infirmary

15-

Filed SEP 17 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th 1917, to Sept 16th 1917, that I saw her alive on Sept 16th 1917, and that death occurred, on the date stated above, at 4.38 P.M.

The CAUSE OF DEATH* was as follows:

Gall Stones. Perforated Gall bladder. Operation Sept 14th

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(Duration)...yrs...mos...ds.

(Signed) G.R. Michelette M.D.

Sept 16 1917. (Address) U.P.I.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ? ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1518 Mc Cullough St.

19-PLACE OF BURIAL OR REMOVAL, Leesburg Va — DATE OF BURIAL, Sept 18, 1917.

20-UNDERTAKER Stewart & Mowen Company — ADDRESS 108 W Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8509

CERTIFICATE OF DEATH.

104 D 8509

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 Moore ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Paterson

(Residence in Baltimore: No. 545 moore st St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, June. (Month) 10 (Day), 1916 (Year)

7-AGE, 1 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none -
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto md -

PARENTS.

10-NAME OF FATHER, William Paterson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Paterson Mother

(Address) 545 Moore St

15-

SEP 17 1917 HARRY C. ANDREWS Burial Permit Clerk

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 17 1917, that I saw h[er] alive on Sept 16 1917, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Enteros Colitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Defective Feeding

Not known (Duration) yrs. mos. ds.

(Signed) Samuel A. Lewis M. D.

Sept. 17, 1917. (Address) 937 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mont auburn Cemetery

DATE OF BURIAL, Sept 17..., 1917

20-UNDERTAKER John H Toadvine

ADDRESS 1917 42 Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8510

1 PLACE OF DEATH

Registered No. C D 8510

CITY OF BALTIMORE (No. 1221 Madison ave St. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Davies Spear

(Residence in Baltimore: No. 1221 Madison ave St.: Life yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) 10 (Day), 1837 (Year)

7 AGE: 80 yrs. 4 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: James Owen Davies

11 BIRTHPLACE OF FATHER (State or country): U S.

12 MAIDEN NAME OF MOTHER: Louisa Douglass

13 BIRTHPLACE OF MOTHER (State or country): Fayetteville Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A Spear

(Address) 1221 Madison ave

15 Filed SEP 1 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 16 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from September 4, 191 7 to Sept 16 1917.
that I saw h-- alive on Sept 16 .191 7.
and that death occurred on the date stated above, at 2.30 p m.
The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(Duration) yrs. mos. 12 ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) 1 yrs. — mos. — ds.

(Signed) Hen Pollock M. D.
Sept 16, 191 7 (Address) 1112 Eutaw St north

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Sept 18, 1917

20 UNDERTAKER: Hilbert W Shriver

ADDRESS: 1018 E Lanvale ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8511

CERTIFICATE OF DEATH.

REGISTERED No. D 8511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 E. Fedral ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Hindle

(Residence in Baltimore: No. 1604 E Fedeal St.; 37 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 0, (Month) (Day) 1837 (Year)

7-AGE, 80 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): G.N.

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Edward Hindle

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Ann Hindle

(Address) 1604 Fedeal St

15-

Filed ....., 191.....

SEP 17 1917 HARRY C. ANDREWS Registrar. Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1917, to Sept 15 1917, that I saw h.. alive on Sept 15 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Disease Asthenia (Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William Hindle M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore City | DATE OF BURIAL, Sept 17, 1917

20-UNDERTAKER Robt J Turner | ADDRESS 1446 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8512

CERTIFICATE OF DEATH.

108 D 8512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 14 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Chesnut

(Residence in Baltimore: No. 1522 Madison Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. July (Month) 29 (Day), 1859 (Year)

7-AGE. 58 yrs. 1 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Jos. H. Medairy

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Caroline Price

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calvin Chesnut

(Address) 1522 Madison Ave

15-

Filed SEP 17 1917, 191.. HENRY O. ANDREWS Clerk Circuit Court

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-13 1917, to 9/16 1917, that I saw h-r alive on 9/16 1917, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic pancreatitis following removal of gall bladder & appendix

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholelithiasis appendicitis (Duration) 1 yrs. mos. ds.

(Signed) C. Kerfoot Mackenzie M. D.

9/16, 191.7. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 4 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1522 Madison Ave.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Sept. 19, 1917.

20-UNDERTAKER John C. Mitchell ADDRESS 1201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8513

CERTIFICATE OF DEATH.

19 D 8513

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred J. Gallup

(Residence in Baltimore: No. 113 N. Fremont Ave St.; 36 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH, Nov. (Month) 20 (Day), 1861 (Year)

7-AGE, 55 yrs. 9 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer):

219 063

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas F. Gallup

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha Canon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Noble C. Gallup

(Address) 115 N. Fremont Ave.

15-

Filed SEP 17 1917, 191.... HARRY O. ANDREWS Registrar of Vital Statistics

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 16 1917, that I saw him alive on Sept 16 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

..... (Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

..... (Duration) unknown yrs. mos. ds.

(Signed) B. B. Brannon M. D.

Sept 16 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. Life mos. ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence 113 N. Fremont Ave

19-PLACE OF BURIAL OR REMOVAL, Perryman, Md.

DATE OF BURIAL, Sept. 18, 1917

20-UNDERTAKER John O. Mitchell

ADDRESS 1208 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 8514

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Crawford St. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank X Katzenberger

(Residence in Baltimore: No. 607 Crawford St.; St.: 55 yrs. .. mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 6 (Day) 1838 (Year)

7-AGE, 79 yrs. 2 mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wood Turner
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 086

9-BIRTHPLACE, (State or Country), Ohio.

PARENTS.

10-NAME OF FATHER, Louis Katzenberger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Schneider.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary T. Katzenberger

(Address) 120 S. Riverside Ave.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8th 1917, to Sept. 15th 1917, that I saw h— alive on Sept. 15th 1917, and that death occurred, on the date stated above, at 10.10 a.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 6 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .....

(Duration) .... yrs. .... mos. .... ds.

(Signed) Thomas Stroud M.D. M. D.

Sept. 15th, 1917. (Address) 2537 Gunnell Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Catholic Cemetery DATE OF BURIAL, Sept. 18th, 1917.

20-UNDERTAKER Jno. J. Fahey & Sons ADDRESS 318 Eastern Ave.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. OCCUPATION should be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8515

D 8515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1362 N Stricker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Asenath Strother

(Residence in Baltimore: No. 1362 N Stricker St.; yrs. 4 mos. ds.)

all life in City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... Jan 12 (Month) (Day), 1893 (Year)

7-AGE, 24 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Wife 086
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Music Teacher 166

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Vincent T. Lawson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Virginia Dyers

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Lawson

(Address) 1515 Riggs Ave

15-

Filed ....., 191.....

HARRY O. ANDREWS
SEPT 1917
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1917, to Sept 15 1917, that I saw her alive on Sept 14 1917, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculosis

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

..... (Duration) yrs. mos. ds.

(Signed) Wm. N. Wright M. D.

Sept. 15, 1917. (Address) 1209 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	Sept. 17, 1917.
20-UNDERTAKER Samuel J. Kemsley	ADDRESS 518 N Carey

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. CONFIDENTIAL RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Katherine Nowak

D 8516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8516

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Gough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Novak

(Residence in Baltimore: No. 1913 Gough St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, November (Month) ..... (Day), 1846 (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 11 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Germany (Poland)

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany (Poland)

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany (Poland)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Augustinak

(Address) 1913 Gough St.

15-

SEP 17 1917 HARRY C. ANDREWS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1 1917, to Sept 14 1917, that I saw h er alive on Sept 14 1917, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Edema, Intestinal Obstruction, Arteriosclerosis, Cardiac Degeneration

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Heart failure & arteriosclerosis

(Duration) yrs. mos. 4 ds.

(Signed) Thos. A. Dunbar M. D.

Sept 15, 1917 (Address) 1621 E. Fourth Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus, DATE OF BURIAL, Sept 18, 1917

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 8517

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 S. Dallas ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Krysiak (Krysiak)

(Residence in Baltimore: No. 727 S. Dallas. St.; 4 yrs., 11 mos. 18 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 30, 1916 (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Michael Krysiak

11-BIRTHPLACE OF FATHER (State or Country), German Poland

12-MAIDEN NAME OF MOTHER Frances Dregan

13-BIRTHPLACE OF MOTHER (State or Country), German Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Krysiak

(Address) 727 S. Dallas St.

15-

Filed SEP 1 7 1917, 191.....

HARRY D. ANDREWS
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 15 1917, that I saw him alive on Sept 15 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Primary (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Wm. D. Bullock M. D.

....., 191... (Address) 1621 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Sept. 18, 1917

20-UNDERTAKER W. F. Sadowski — ADDRESS 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

D 8518 HEALTH DEPARTMENT—CITY OF BALTIMORE 1/20

D 8518

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 D. Green ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Clark Taylor

(Residence in Baltimore: No. 610 D. Green St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 15 (Day), 1873 (Year)

7-AGE, 44 yrs. 3 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Raleigh NC

PARENTS.

10-NAME OF FATHER, Samuel Taylor

11-BIRTHPLACE OF FATHER (State or Country), N C

12-MAIDEN NAME OF MOTHER Mamie Pope

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie B. Taylor

(Address) 610 S. Green St

15-

Filed SEP 17 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 16 1917, that I saw her alive on Sept 15 191..., and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

6?

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. M. Ducett M. D.

Sept 16, 191.7 (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery

DATE OF BURIAL, Sept 18, 191.7

20-UNDERTAKER Geo H Hooper

ADDRESS 609 Little Sharp

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state all information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CONFIDENTIAL RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8519

CERTIFICATE OF DEATH.

D 8519

REGISTERED No. C 157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 658 Cider Av ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Pierce

(Residence in Baltimore: No. 658 Cider Av St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 16, 1917
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 2 hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Elmer Parker

11-BIRTHPLACE OF FATHER (State or Country), Accamack, Va.

12-MAIDEN NAME OF MOTHER Francis Pierce

13-BIRTHPLACE OF MOTHER (State or Country), Cantyland Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Parker

(Address) 658 Cider Av

15-

SEP 17 1917

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 16 1917, to September 16, 1917, that I saw her alive on September 16, 1917, and that death occurred, on the date stated above, at 9-55 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) L. H. Douglass M. D.

9-16-, 191.7. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Gt Auburn Cemtry

DATE OF BURIAL, 9/18, 1917.

20-UNDERTAKER Geo H. Hooper

ADDRESS 607 Little Sarat

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8520.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8520.

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Eastern Ave. St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anttony J. Iannerelli

(Residence in Baltimore: No. 911 Eastern ave. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Dec. 29th ....., 1916
(Month) (Day) (Year)

7-AGE, ...1.... yrs. ....8.... mos. ....17.... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Michael Iannerelli

11-BIRTHPLACE OF FATHER (State or Country). England.

12-MAIDEN NAME OF MOTHER Mary Lavazza

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Iannerelli

(Address) 911 Eastern Ave

15- SEP 17 1917 ROBERT B. KRAUTER

Filed ....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 15 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Sept 15 1917, that I saw h— alive on Sept 15 1917, and that death occurred, on the date stated above, at 6 40 a.m.

The CAUSE OF DEATH* was as follows:

Poisoned by Drinking
Number of Bottles
Contributory

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Sept 18, 1917.

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8521

CERTIFICATE OF DEATH.

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D 8521

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Emma Schaeck

(Residence in Baltimore: No. Brooklyn A.A. Co. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 23, 1891 (Month) (Day) (Year)

7-AGE, 20 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Muller

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles A Schaeck (Husband)

(Address) Frederick st Brooklyn A.A.Co.

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Sept 15 1917, that I saw h[er] alive on Sept 15 1917, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Not known (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Frank C. Marino M. D.

Sept. 15, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 26 yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Brooklyn A.A. Co.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Sept 18, 1917.

20-UNDERTAKER Armstrong Denny Co — ADDRESS 715 Light st

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8522

CERTIFICATE OF DEATH.

151 ✓ D 8522

REGISTERED No. C

1-PLACE OF DEATH West End Mty

CITY OF BALTIMORE: (No. 112 N. Calhoun ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delores Flack

(Residence in Baltimore: No. ..... St.: ..... yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	

6-DATE OF BIRTH, Sept (Month) 15 (Day), 1917 (Year)

7-AGE, ... yrs. 4 mos. 4 ds.

If LESS than 1 day, ... hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), West End Mty, City

PARENTS.

10-NAME OF FATHER, Benj Flack

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mildred Bengle

13-BIRTHPLACE OF MOTHER (State or Country), Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.... SEP 17 1917 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 15 1917, that I saw h er alive on Sept 15 1917, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hammond M. D.

Sept 15 1917 (Address) Calhoun & Biggs

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL ... LIBRARY Social Farm Bldg.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15164

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH D 8523 **CERTIFICATE OF DEATH.** 79X D 8523

CITY OF BALTIMORE (No. Montgomery & China Sts. St.: 22 WARD) REGISTERED No. C

2-FULL NAME Wilson Schavias.(C)

(Residence in Baltimore: No. None. St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know. ....., ..., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
35 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 076

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Otto M. Reinhardt, M.D.....

(Address).....Coroner.....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th. 1917. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.
(Inquest, autopsy or inquiry.) (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed) Otto M. Reinhardt M. D.

Sept. 17, 1917 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence Newport News Va.

19-PLACE OF BURIAL, OR REMOVAL, | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

SEP 3 1917 ROBERT B. BRAUER JOHNS HOPKINS HOSPITAL Undertaker Health

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8524

109 D 8524

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Cook

(Residence in Baltimore: No. 108 Columbus Rd St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Contracting Co

9-BIRTHPLACE, (State or Country). Alabama

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), / /

12-MAIDEN NAME OF MOTHER / /

13-BIRTHPLACE OF MOTHER (State or Country), / /

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Moses Cook

(Address) 108 Columbus Rd

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Traumatic Pneumonia

Hernia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Ethmoidal Abscess

(Duration) yrs. mos. 4 ds.

(Signed) James M Kemler M. D. (Coroner.)

Sept 7 1917. (Address) 711 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 108 Columbus Rd

Former or usual residence Alabama

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL SEP 17 1917

Commissioner Health

D 8525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8525

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 404 S Dallas St.; WARD) 3 (White)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Mina

(Residence in Baltimore: No. 404 S. Dallas St. St.; 1 yrs., mos. 15 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 1, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Mina

11-BIRTHPLACE OF FATHER (State or Country), Russ Poland

12-MAIDEN NAME OF MOTHER Bronislawa Jankin

13-BIRTHPLACE OF MOTHER (State or Country), Russ Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Mina

(Address) 404 S Dallas St

15-

Filed....., 191.....
Registrar.

SEP 17 1917

ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 17, 1917 (Address) 606 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Sept 19, 1917
20-UNDERTAKER	ADDRESS
M. Gallovich	1616 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 8526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8526

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Eastern Ave ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Bonylincha

(Residence in Baltimore: No. 1625 Eastern Ave St.; ....yrs., 3 mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. DEPARTMENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ...July.... (Month) 10 (Day), 1916 (Year)

7-AGE, ...1....yrs. 12....mos. 6....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), N. Jersey.

PARENTS.

10-NAME OF FATHER, Karl Bonylincha

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kate Sadoski.

13-BIRTHPLACE OF MOTHER (State or Country), Austria.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H H Cathrall

(Address) Johns Hopkins Hospital

15-

SEP 17 1917

Filed....., 191.... ROBERT E. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 17 1917, that I saw her alive on Sept 17 1917, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

.....

..... Acute Bronchial Intestinal

..... Indigestion

..... (Duration)....yrs....mos. 2 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs....mos....ds.

(Signed) J. M. Russ M. D.

9/17....., 191.7. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept. 18, 1917.

20-UNDERTAKER, William Fradbrooks — ADDRESS 618 Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8527.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8527.

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; ward 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Whyte

(Residence in Baltimore: No. 108 N. Greene St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Feb 22nd (Month) (Day), 1884 (Year)

7-AGE, 33 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer) 029

9-BIRTHPLACE, (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, Louis Davenport

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia

12-MAIDEN NAME OF MOTHER Adline Davenport

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathaniel B. White

(Address) 108 N. Green St.

15-

Filed....., 191.....

Registrar.

SEP 17 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 15 1917, that I saw h[illegible] alive on Sept 15 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Salpingitis

(Duration) yrs. mos. 3 ds.

(Signed) Frank C. Marino M. D.

Sept 15, 191. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. 2 mos. ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence 108 N. Greene St

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa

DATE OF BURIAL, Sept 18, 191. 7

20-UNDERTAKER John A Moran

ADDRESS Bank & Ann Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8528

CERTIFICATE OF DEATH.

28 D 8528

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N Madeira ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Roberts

(Residence in Baltimore: No. 127 N. Madeira St.; Life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 31 (Month) (Day), 1871 (Year)

7-AGE, 46 yrs. 7 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborman 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Lumber Co.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Casper Roberts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Roberts

(Address) 127 W. Madeira St

15-

Filed ....., 191.....

Registrar.

SEP 17 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1916, to Sept 14 1917, that I saw him alive on Sept 13 1917, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) —

..... (Duration) — yrs. — mos. — ds.

(Signed) William H. Johnson M. D.

Sept 17, 1917 (Address) 3016 Guilford Ave

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loch Raven — DATE OF BURIAL, Sept 18, 1917

20-UNDERTAKER Robt Turner — ADDRESS 1442 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8529

1-PLACE OF DEATH St Joseph's Hospital REGISTERED NO. C 126

CITY OF BALTIMORE: (No. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Stone

(Residence in Baltimore: No. 2612 N. Charles St St.: 61 yrs., 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October 11th, 1865
(Month) (Day) (Year)

7-AGE, 61 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Banker
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James H Stone

11-BIRTHPLACE OF FATHER (State or Country), Massachusetts

12-MAIDEN NAME OF MOTHER Harriett Newell Russell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Clara Roberts Stone

(Address) 2612 N. Charles St

15-

SEP 17 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7th 1917, to Sept 16 1917, that I saw h[illegible] alive on Sept 16 1917, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows: Acute Hemorrhagic Retention resulting from Enlarged Prostate Gland

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cellulitis of Abdominal Wall

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Myles B. Starkey M. D.

Sept 16, 1917 (Address) St Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Home.

Former or usual residence 2612 N. Charles

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Sept. 19th, 1917.

20-UNDERTAKER Geo Schilling & Sons

ADDRESS 1162 Monument St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

600

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8530

CERTIFICATE OF DEATH.

120 ✓ D 8530

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Greenmount ave St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C Heiligenstadt

(Residence in Baltimore: No. 1026 Greenmount ave St.: 35 yrs., 8 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 8th, 1882
(Month) (Day) (Year)

7-AGE, 35 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocery Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Henry Heiligenstadt

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie K Heiligenstadt

(Address) 1026 Greenmount ave

15- SEP 7 1917 ROBERT B. KRAUTER Burial Permit

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16th 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14th 1917, to Sept 16th 1917, that I saw him alive on Sept 15th 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) 1 yrs. mos. ds.

(Signed) C Bozick M. D.

Sept 16 1917. (Address) 605 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Sept. 18th, 1917.

20-UNDERTAKER George J Nilling & Sons

ADDRESS 1126 E Monument

605 N. Charles

IMPORTANT—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8531

CERTIFICATE OF DEATH.

120 D 8531

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 W Fayette ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erixon L. Lumberson

(Residence in Baltimore: No. 1808 W Fayette st

St.: 72 yrs., 11 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, September (Month) 27th (Day), 1844 (Year)

7-AGE, 72 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or.....mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Lumberson

11-BIRTHPLACE OF FATHER (State or Country), Tennessee

12-MAIDEN NAME OF MOTHER Morgaret Newcomer

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Lumberson

(Address) 1808 W Fayette st

15-

SEP 17 1917 ROBT. R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 16 1917, and that death occurred, on the date stated above, at 11 35 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia Convulsions

(Duration) — yrs. — mos. 4 ds.

(Signed) John T. Finch M. D.

Sept 17 1917 (Address) 1325 Monument st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Sept 20th, 1917
20-UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Entire item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

MEDICAL CERTIFICATE

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8532 ✓ D 8532

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Wilcox St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Arrandale

(Residence in Baltimore: No. 1206 Wilcox St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 1 (Day), 1883 (Year)

7-AGE 34 yrs. 4 mos. 15 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Troy N. Y.

PARENTS.

10-NAME OF FATHER, John Butterfield.

11-BIRTHPLACE OF FATHER (State or Country), Troy N. Y.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Australia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold Arrandale

(Address) 1206 Wilcox St

15-

Filed ....., 191....

ROBERT B. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1916, to 16 Sept 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 740 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. 6 mos. 12 ds.

CONTRIBUTORY (Secondary) Lungs

(Duration) yrs. 6 mos. 12 ds.

(Signed) L. Gill Kessaard M. D.

Sept 16, 1917. (Address) 708 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross

DATE OF BURIAL, Sept 19, 191...

20-UNDERTAKER Wm Cook

ADDRESS 5025 North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8533

CERTIFICATE OF DEATH.

113 ✓ D 8533

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3640 Maple Ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucinda E Bowers

(Residence in Baltimore: No. 3640 Maple Ave St.; 72 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 7 (Day), 1845 (Year)

7-AGE, 72 yrs. 1 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Howard Co. Md

PARENTS.

10-NAME OF FATHER, Richard Frost

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Kreuter

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bowers

(Address) 3640 Maple Ave

15-

Filed ....., 191.....

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1917, to Sept 15 1917, that I saw her alive on Sept 14 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with Ascites

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Edward J. Gorman M. D.

9/15, 1917 (Address) 1423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westminster Maryland — DATE OF BURIAL, Sept. 18, 1917

20-UNDERTAKER Sullivan Cook — ADDRESS 509 E North Avenue

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GOVERNMENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8534

CERTIFICATE OF DEATH.

D 8534

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lazelle Van Dewater

(Residence in Baltimore: No. University Hospital St.; 8 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, November 1st, 1841
(Month) (Day) (Year)

7-AGE, 75 yrs. 10 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Philadelphia, Pa

PARENTS.

10-NAME OF FATHER. Conrad Van Dewater

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Martin

(Address) Univ Hosp Balto

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 17 1917, that I saw h m alive on Sept 17 1917, and that death occurred, on the date stated above, at 6.55 8 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinomatosis of Peritoneum

(Duration) at least 2 yrs. (mos. ds.

(Signed) H. Thalheimer M. D.

9/19, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 2 mos. 8 ds. In the State 75 yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Hamilton Md.

19-PLACE OF BURIAL OR REMOVAL, Western Cem.

DATE OF BURIAL, Sept, 1917

20-UNDERTAKER Joseph D Cook

ADDRESS 1002 W Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GOVERNMENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8535

CERTIFICATE OF DEATH.

D 8535

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 S. Furrow St. ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Yeager [Strzelecki]

(Residence in Baltimore: No. 306 S. Furrow St. St.; 50 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH, ... Not Known, 1 .....
(Month) (Day) (Year)

7-AGE, 67 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) ..... House Wife

9-BIRTHPLACE, (State or Country), France

PARENTS.

10-NAME OF FATHER, Martin Geiser

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Martin Strzelecki

(Address) ..... 306 Furrow St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1917, to Sept 15 1917, that I saw h... alive on Sept. 15 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Liver.
(b) Metastasis
(Duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart
(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

Sept 16, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ... mos. 7 ds. In the State ..... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 306 Furrow St

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Sept 18, 1917.

20-UNDERTAKER Stephen J. Fralkowski ADDRESS 1019 S. Kenwood Ave

SEP 1 1917 ROBERT D. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

D 8536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8536

REGISTERED No. C

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2303 Eastern ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Merkel Gordens

(Residence in Baltimore: No. 2303 Eastern ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, May (Month) 16 (Day), 1917 (Year)

7-AGE, ...yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

000 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Brill

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Marie Jorden

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Brill

(Address) 2303 Eastern ave

15-

SEP 17 1917 ROBERT E. KRAMER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquisition find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dis Colitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Harry Dorsey Gruby M. D.
(Coroner.)

Sept 17, 191.. (Address) 1618 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, St Vincent

DATE OF BURIAL, Sept 18, 1917

20-UNDERTAKER Kendall Duffy Co

ADDRESS 378 Pa ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D. 8537.

CERTIFICATE OF DEATH.

79 D. 8537.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Pfeiffer Court St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Makowski

(Residence in Baltimore: No. 2423 Pfeiffer Court St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov 19th, 1844
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 9 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House 600
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Mercer

(Address) 2423 Pfeiffer Court

15-

SEP 17 1917 ROBERT R. KRAUSER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1917, to Sept 16th 1917, that I saw her alive on Aug 26th 1917, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Fibroid Degeneration of the Myocardium

Acute ..... (Duration)....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (Endarteritis)

Acute ..... (Duration)....yrs.....mos.....ds.

(Signed) J. Albert Muller M. D.

Sept 17, 1917. (Address) 2137 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 19, 1917.

20-UNDERTAKER Wendell Duffield — ADDRESS 378 N.

EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

17 D 8538

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 8538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2128 Morris ST.: 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Richardson

(Residence in Baltimore: No. 2128 Morris St. 1 yrs., 6 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colo

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, [illegible] 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. [illegible] mos. [illegible] ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Oyster Opener
(b) General nature of industry, business, or establishment in which employed (or employer): Packer

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Hinsley Richardson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Cortis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 2128 Morris

15-

Filed SEP 18 1917, 191.... ROBT. C. ANDREWS Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Cerebral Hemorrhage

(Duration) 1 yrs. [illegible] mos. 2 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 17, 191.7. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State [illegible] yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 19, 1917

20-UNDERTAKER Mrs R A Elliott ADDRESS 506 East Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8539 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8539

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5. S Bethel ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Ellis

(Residence in Baltimore: No. 5. S Bethel St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH, Unknown, 1865 (Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Dodson

(Address) 5. Bethel

15-

Filed SEP 18 1917 191 HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 191 7, to Sept 15 191 7, that I saw her alive on Sept 15 191 7, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Pleurisy and Effusion

(Duration) 1 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 3 yrs. 3 mos. ds.

(Signed) Thos H Maguire M. D.

9.17.7, 191. (Address) 1516 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetary

DATE OF BURIAL, Sept 18., 1917

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 East-A

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8510

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 8510

CERTIFICATE OF DEATH.

50

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Md Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Nisbet

(Residence in Baltimore: No. 1927 East 31st St. St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, February 1, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. 7 mos. 15 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chemical Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Working Supt. 06

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Thomas Nisbet.

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Margaret White

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Nisbet

(Address) 1923 E. 31st St

15-

Filed....., 191.....

SEP 18 1917

HARRY L. ANTHONY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 16th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1917, to Sept 16 1917, that I saw h[im] alive on Sept 16 1917, and that death occurred, on the date stated above, at 5-10 P m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage
Edema of Lungs
Supra Pubic Catheterism
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes & Mitral Insuff,
(Duration) — yrs. — mos. — ds.

(Signed) L. Martin M. D.

....., 191... (Address) Univ Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11th ds. In the State 6 yrs. mos. ds.

Where was disease contracted, if not at place of death? Baltimore

Former or usual residence 1927 East 31st St City

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Sept. 17, 1917.

20-UNDERTAKER John B. Spence — ADDRESS 1325 N. Caroline St

IN ITEMS 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20 every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8541

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Della Hyde

(Residence in Baltimore: No. Mercy Hospital St.; ..... yrs., ... mos. 13 yrs. 4 mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Married

6-DATE OF BIRTH, Unknown 1 .....
(Month) (Day) (Year)

7-AGE, 40? yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Private 241

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Sam. Hilsin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margt Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev [illegible]

(Address) Mercy Hospital

15-

Filed SEP 18 1917, 191.....
HARRY C. [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 16 191..., to Sept 16 191...,
that I saw h alive on Sept 16 191...,
and that death occurred, on the date stated above, at 10:50 a.m.
The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward T. Smith M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 13 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? [illegible] Waterville Md

Former or usual residence Waterville Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Waterville and Co: Md.	Sept. 17, 191 7.
20-UNDERTAKER Felix B. Pye	ADDRESS 102 E. Mulberry

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BUREAU OF VITAL STATISTICS RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8542 D 8542

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH 622 Wayne St

CITY OF BALTIMORE: (No. [illegible] ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Callahan

(Residence in Baltimore: No. 623 Wayne St.; 40 yrs., 4 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 22, 1877 (Month) (Day) (Year)

7-AGE, 40 yrs. 4 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Bal O RR.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Mackelry Callahan

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Lottie Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Callahan

(Address) 622 Wayne St

15-

SEP 18 1917 HARRY C. ANDREWS Burial Permit Clerk

Filed....., 191... .....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 17 1917, and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, 7 d

....., (Duration)....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary)

..... (Duration)....yrs....mos. 5 ds.

(Signed) [illegible] M. D.

Sept 19, 1917 (Address) 714 S. [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt auburn Cem — DATE OF BURIAL, Sept 18, 1917

20-UNDERTAKER J L Brownell Sons — ADDRESS 1017 W. Mosby

U. S. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GOVERNMENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8543 — 79 ✓ — D 8543

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3600 Garrison ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charlotte Schmidt

(Residence in Baltimore: No. 36[illegible] Garrison Ave St.: 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April 12, 1842 (Month) (Day) (Year)

7 AGE: 70 yrs. 5 mos. 3 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Home work

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: John Kraft

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Antinett Plitt

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ludwig Schmidt
(Address) 3600 Garrison ave

15
Filed SEP 18 1917, 191 MARY C. ANDREWS
Burial Permit
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 15, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1916, to Sept 15 1917, that I saw h[illegible] alive on Sept 14, 1917, and that death occurred, on the date stated above, at 12.30 m.
The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

Fatal Mor:

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Ext Cerebra + Pul. Oedema

(Duration) yrs. mos. 5 ds.

(Signed) Frank S. Moyer M. D.

Sept 17, 1917 (Address) 150 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 19, 1917

20 UNDERTAKER: W M Routson — ADDRESS: 230 N Greene

D 8544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

-40 ✓

D 8544

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2206 Walbrook Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Dora Baer

(Residence in Baltimore: No. 2206 Walbrook ave St.: 10 yrs. — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWER OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Aug (Month) 12 (Day), 1856 (Year)

7 AGE: 61 yrs. 1 mos. 5 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: L. Isaacs

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Baer

(Address) 2206 Walbrook Ave

15

Filed SEP 18 1917, 191 — HARRY C. ANDREWS — Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1917, to Sept 17 1917, that I saw h[er] alive on Sept 17, 1917, and that death occurred, on the date stated above, at 1 6 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

Primary

(Duration) yrs. 1 mos. 4 ds

Contributory (SECONDARY) Cardiac exhaustion

Toxemia

(Duration) yrs. — mos. 10 ds.

(Signed) I. Frederick Lutz M. D.

Sept 18, 1917 (Address) 2040 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Friendship Cem. — DATE OF BURIAL: Sept 19 17

20 UNDERTAKER: Chas Sondheim — ADDRESS: 115 W. Lexington

Spec.—8-24-14—M. & T.—2000 Bks.

D 8515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8515

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 W Mulberry St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm P Newman

(Residence in Baltimore: No. 521 W. Mulberry St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, July 22nd, 1853
(Month) (Day) (Year)

7-AGE, 63 yrs., 1 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Wm Newman

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary J Mulvany

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Newman

(Address) 521 W. Mulberry

15-

Filed ....., 191....

Registrar.

SEP 1 1917 MARY C. ANDREWS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 16 1917, that I saw h[illegible] alive on Sept 13 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (Duration) yrs. 10 mos. ds.

(Signed) Arthur P Norman M. D.

Sept 18, 1917. (Address) 36 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Sept 19 1917

20-UNDERTAKER John A Duncan — ADDRESS [illegible]

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8546

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 Bernard St ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Rebecca Merryman

(Residence in Baltimore: No. 2733 Bernard St St.; 68 yrs., 1 mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 23 (Day) 1849 (Year)

7-AGE, 68 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Eaton

11-BIRTHPLACE OF FATHER (State or Country), Balti. Co. Md

12-MAIDEN NAME OF MOTHER Agnes Eaton

13-BIRTHPLACE OF MOTHER (State or Country), Balti. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Paul

(Address) 2733 Bernard St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Sept 17 1917, that I saw h alive on Sept 16 1917, and that death occurred, on the date stated above, at 11.40a m.

The CAUSE OF DEATH* was as follows:

1a Hypostatic pneumonia, 3 days

b Chronic Nephritis

c Arteriosclerosis

(Duration) 1 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) General Debility

(Duration) 1 yrs. 2 mos. 1 ds.

(Signed) E. J. E. Bayne M. D.

Sept. 17, 1917. (Address) Cockeysville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Black Rock Balto Co Md | DATE OF BURIAL, Sept. 19, 1917.

20-UNDERTAKER Thomas Ths & Son | ADDRESS 361 Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8547

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3321 Brech Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Permar.

(Residence in Baltimore: No. 3321 Brech. Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 30, 1862.
(Month) (Day) (Year)

7-AGE, 54 yrs. 10 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Police Officer
(b) General nature of Industry, business, or establishment in which employed (or employer): City / 61

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, Parrot Permar

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Hilton

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Permar.

(Address) 3321 Brech Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 15 1917,

that I saw him alive on Sept 15 1917,

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis Embolism

(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hemorrhage Cerebral

(Duration) 10 yrs. ..... mos. 1 ds.

(Signed) Vernon D. Kelly M. D.

Sept 16 1917. (Address) 3704 Jacksonwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. | DATE OF BURIAL, Sept 17, 191...

20-UNDERTAKER Dunworth & Lord | ADDRESS Eastern Ave

I.C.C. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HARRY O. ANDREWS
SEP 18 1917
REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

D 8543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8543

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Townsend Pl. St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Westerfeld

(Residence in Baltimore: No. 1731 Townsend Pl. St.; 7 yrs., 1 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, August 1, 1910 (Month) (Day) (Year)

7-AGE, 7 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer). Girl

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frederick Westerfeld

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Mary Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Westerfeld

(Address) 1731 Townsend Pl

15-

Filed....., 191.....

Registrar.

SEP 18 1917

HARRY C. ANDREWS
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 16 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 14 ds.

(Signed) John T Carey M. D.

Sept 16, 1917. (Address) 1603 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Co. DATE OF BURIAL, Sept 18, 1917.

20-UNDERTAKER Wm Leach ADDRESS 502 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

804

Spec.—8-24-14—M. & T.—2000 Bks.

D 8519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 8519

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N. Streeper ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J. Breslendorf

(Residence in Baltimore: No. 725 N. Streeper St. St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 21, 1844
(Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gm Breslendorf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret G. Breslendorf

(Address) 725 N. Streeper st

15-

Filed SEP 18 1917, 191.....

MARY C. LEE
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Sept 16 191(7), that I saw h[im] alive on Sept 15th 191(7), and that death occurred, on the date stated above, at 11 25 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia, Mitral Valve

(Duration) 2 wks yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy

(Duration) 11 yrs. mos. ds.

(Signed) J. S. Stone M. D.

Sept 16, 1917, (Address) 624 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Trinity Cemetery	Sept. 19..., 191.7.
20-UNDERTAKER Albert E. Faulks	ADDRESS 721 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17
31
D 8550

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 8550

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 503 Oxford ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannie Yates

(Residence in Baltimore: No. 503 Oxford

St.; yrs., 31 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, August (Month) (Day) 1886 (Year)

7-AGE, 31 yrs. August mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Mrs. [illegible]

9-BIRTHPLACE, (State or Country), Balto., Md

PARENTS.

10-NAME OF FATHER, Robt. Yates

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jennie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Jones

(Address) 503 Oxford St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cold & Grippe

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 17, 1917 (Address) 219 N Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept 18 1917

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pennsylvania

Spec.—8-24-14—M. & T.—2000 Bks.

3084

D 8551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓ D 8552

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 Sterling St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geraldine Yates

(Residence in Baltimore: No. 643 Sterling St St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored a a

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Un known (Month) (Day) 1 (Year)

7-AGE, 1 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Joseph Yates

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Mary E Clark

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Yates

(Address) 643 Sterling St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 16 1917, that I saw he alive on Sept 16 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(b) Primary

(c)

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Condylomata

(Duration) yrs. mos. ds.

(Signed) Albert K. Ley M. D.

9/17/17, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury cemetery

DATE OF BURIAL, Sept 18, 1917

20-UNDERTAKER R E Gross

ADDRESS 1405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CITY DEPARTMENT RECORD

SEP 18 1917 MARY C. ANDREWS Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

D 8552 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8552

CERTIFICATE OF DEATH.

REGISTERED No. C 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 McElderry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Williamson Jr.

(Residence in Baltimore: No. 1429 McElderry St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored a.a	Single

6-DATE OF BIRTH, Sept. 5, 1917
(Month) (Day) (Year)

7-AGE, ..yrs. ..mos. 11 ds. If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Samuel Williamson

11-BIRTHPLACE OF FATHER (State or Country), ~~Md~~ N. C

12-MAIDEN NAME OF MOTHER Sadie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Williamson

(Address) 1429 McElderry St

15-

SEP 18 1917

Filed ....., 191.... HARRY C. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1917, to Sept. 16 1917, that I saw h[illegible] alive on Sept. 16 1917, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..yrs. ..mos. 6 ds.

CONTRIBUTORY (Secondary) Intestinal Catarrh

(Duration) ..yrs. ..mos. 2 ds.

(Signed) Jno. C. Williamson M. D.

9/17, 1917 (Address) 1520 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon cemetery — DATE OF BURIAL, Sept. 18 1917

20-UNDERTAKER R. L. Gross — ADDRESS 1405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8553

REGISTERED No. C 104 D 8553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Aisquith ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Louise Mancuso.

(Residence in Baltimore: No. 1017 Aisquith st St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Sept (Month) 18th (Day), 1917 (Year)

7-AGE, 1 year. ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Sigismundo Mancuso

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Maria Mantallo.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sigismundo Mancuso

(Address) 1017 Aisquith st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8th 1917, to Sept 18 1917, that I saw her alive on Sept 18 1917, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

ac. entero-colitis

(Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.

....., 191... (Address) 210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, Sept 19 191...

20-UNDERTAKER George J. Roth.

ADDRESS 735 Hanover

D 8554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 2 0 D 8554

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1541 Myrtle Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Williamson Gorr

(Residence in Baltimore: No. 1541 Myrtle ave

Sta. Yrs. Life mos. ds.)

THIS IS A PERMANENT RECORD

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH. Aug (Month) 19 (Day), 1856 (Year)

7-AGE. 61 yrs. 28 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE. (State or Country): Md

PARENTS.

10-NAME OF FATHER: John M Gorr

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah J Askew

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1220 N. Fremont Ave

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cal & Hydrem

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 6, 191 7 (Address) 1918 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State None yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery DATE OF BURIAL, Sept 20 17

20-UNDERTAKER [illegible] ADDRESS 130 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8555 D 8555

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Light St. 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marian Donaldson

(Residence in Baltimore: No. 1700 Light St.: ~ yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 12, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work...? None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Alfred D. Donaldson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Clara Skelton

13-BIRTHPLACE OF MOTHER (State or Country), Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Donaldson

(Address) 1700 Light St.

15-

Filed SEP 18 1917, 191.... HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 17 1917, and that death occurred, on the date stated above, at 6 X m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

Primary (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

Sept 17 1917 (Address) 1600 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Sept. 19, 1917.

20-UNDERTAKER Fredk A. Krance ADDRESS 703 Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8556

CERTIFICATE OF DEATH.

113

D 8556

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 E Preston St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Petri

(Residence in Baltimore: No. 2327 E Preston St.; 35 yrs., 6 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. February 27, 1882
(Month) (Day) (Year)

7-AGE. 35 yrs. 6 mos. 21 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Color Examiner
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE. (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER. Jacob Petri

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Philippina Schaefer

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Klosfel

(Address) 2327 E. Preston St.

15-

SEP 18 1917

ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 31 1917, to Sept 18 1917, that I saw h[im] alive on Sept 18 1917, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(Duration) 5 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Stomach Ulcer

unknown (Duration) .... yrs. .... mos. .... ds.

(Signed) D. P. Henson M. D.

Sept 18, 1917. (Address) 130 N. Gay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery — DATE OF BURIAL. Sept. 20, 1917.

20-UNDERTAKER Henry Hoech Son — ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D 8557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8557

CERTIFICATE OF DEATH.

82

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2428 Arunah Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Kirby

(Residence in Baltimore: No. 2428 Arunah Ave St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, August 17th (Month) (Day), 1851 (Year)

7-AGE,	If LESS than 1 day,
66 yrs. 1 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): D...

9-BIRTHPLACE, (State or Country) St Marys Co Md

PARENTS.

10-NAME OF FATHER, James Kirby

11-BIRTHPLACE OF FATHER (State or Country). St Marys Co Md

12-MAIDEN NAME OF MOTHER Sarah Carpenter

13-BIRTHPLACE OF MOTHER (State or Country). St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Kirby (daughter)

(Address) 2428 Arunah Ave

15-

SEP 18 1917 ROBERT B. KRAUTER

Filed ....., 191.... REGISTRAR OF VITAL STATISTICS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 16th; 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1917, to Sept 16th 1917, that I saw h.im alive on Sept 11th 1917, and that death occurred, on the date stated above, at 11.40 p.m.

The CAUSE OF DEATH* was as follows:

1. Ch. Endarteritis
Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(Duration) 6 yrs. 1 mos. 7 da.

(Signed) J. W. Kown M. D.

Sept 17, 1917. (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Sept 19, 191.7

20-UNDERTAKER J. B. Kephart

ADDRESS 1136 Fredk Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Anna C. Seigler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8558

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2936 E Balto St. WARD)

CERTIFICATE OF DEATH.

172 D 8558

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma C. Seigler

(Residence in Baltimore: No. 2936 E Balto St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June 26, 1840
(Month) (Day) (Year)

7-AGE, 76 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Richard Richter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Murray

(Address) 2936 E Balto St

15-

Filed SEP 18 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Immediate [illegible] paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 18 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death [illegible] yrs. mos. ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death? 2936 E Balto St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Phoenixville, Pa. DATE OF BURIAL, Sept 19th, 1917

20-UNDERTAKER John A. Moran ADDRESS 3000 E. Baltimore St.

N. B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8559.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8559

1 PLACE OF DEATH — Foot of Kenwood Ave. — REGISTERED No. C.....

CITY OF BALTIMORE: (No. Canton Hollas ... Ward ... Street ...) (If death occurred in a hospital or institution, give its name instead of street and number and fill out No. 18.)

2-FULL NAME antonio E. Marsano

(Residence in Baltimore: No. 1 Day St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: February (Month) 14 (Day), 1885 (Year)

7-AGE: 32 yrs. 7 mos. 3 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Cabin Boy on
(b) General nature of industry, business, or establishment in which employed (or employer): Ship SS Fornio

9-BIRTHPLACE (State or country): Italy

PARENTS

10-NAME OF FATHER: Genseff Marsano

11-BIRTHPLACE OF FATHER (State or country): Italy

12-MAIDEN NAME OF MOTHER: Cacetto Leroon

13-BIRTHPLACE OF MOTHER (State or country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ship Captain

(Address) SS Fornio

15- Filed ..... 191.....

SEP 18 1917 ROBERT R. KRAETER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16, 1917, to, Sept 17 1917, that I saw h.. alive on Sept 16 1917, and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

... (Duration) ... yrs 3 mos. 25 ds.

Contributory (SECONDARY) Acute Malnutrition

... (Duration) ... yrs ... mos. 1 ds.

(Signed), Thos. J. G. Stevens M. D.

Sept 17, 1917 [Address] 2411 E. Preston St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence: Steamship Fornio

19-PLACE OF BURIAL OR REMOVAL: St Vincent — DATE OF BURIAL: Sep 19, 1917

20-UNDERTAKER: Wendell Patterson — ADDRESS: 37 S Amm

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8560

CERTIFICATE OF DEATH.

64 D 8560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Wilkens Ave St.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary N. Tuttle

(Residence in Baltimore: No. 2216 Wilkens Ave St.; 50 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dont Know ..... (Month) ..... (Day) 1847 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
† (b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thos. M. Donnelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Donnelly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dolan

(Address) 2212 Eagle St

15-

SEP 18 1917 ROBERT R. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 16 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. Unknown mos. ..... ds.

(Signed) ..... M. D.

Sept 18, 1917 (Address) 108 N Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Sept 19, 1917
20-UNDERTAKER M. J. Glynn	ADDRESS 1422 Eagle St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D 8561

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 834 W. Fayette ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Epple.

(Residence in Baltimore: No. 834 W. Fayette St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Single.

6-DATE OF BIRTH, ... July 24., 1879.
(Month) (Day) (Year)

7-AGE, 38 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frdk. Epple.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christina. Epple.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Foeller

(Address) 207 N. Belnord. Ave

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 17., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Uns

..... (Duration) ....yrs....mos....ds.

(Signed) C. S. Trivett M. D.
(Coroner)

Sept 18, 1917. (Address) 312 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	Sept. 19., 1917
20-UNDERTAKER M. A. Flynn	ADDRESS 1422 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8562

CERTIFICATE OF DEATH.

D 8562

87

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 East North Ave. St.; 9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dosithee Dillaway

(Residence in Baltimore: No. 1140 East North Ave. St.; 90 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, July 15, 1827
(Month) (Day) 1 (Year)

7-AGE, 90 yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter & Builder

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Dillaway

11-BIRTHPLACE OF FATHER (State or Country), Boston, Mass.

12-MAIDEN NAME OF MOTHER Catherine McConn

13-BIRTHPLACE OF MOTHER (State or Country), Albany, N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Flora Dillaway
(Address) 1140 East North Ave.

15-
Filed ..... SEP 18 1917 ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 22 1917, to September 17 1917, that I saw h[illegible] alive on ..... 16. 1917, and that death occurred, on the date stated above, at 10 h. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Cardio Vascular Renal
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis of Heart
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. M. Hartman M. D.
Sept. 18, 1917. (Address) 1121 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Sept. 19, 1917.

20-UNDERTAKER	ADDRESS
Wm. W. Evans & Son	1050 Eutaw St.

D 8563 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 8563

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Cor Charles & Henrietta Sts. 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Johnson.(C)

(Residence in Baltimore: No. None. St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, Do not know. (Month), / (Day), (Year)

7-AGE,	If LESS than 1 day,
47 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer on a
(b) General nature of industry, business, or establishment in which employed (or employer): Farm.

9-BIRTHPLACE, (State or Country), St.Marys Co.Md.

PARENTS.

10-NAME OF FATHER, George Johnson.(C)

11-BIRTHPLACE OF FATHER (State or Country) St.Marys Co.Md.

12-MAIDEN NAME OF MOTHER Annie.--------(C)

13-BIRTHPLACE OF MOTHER (State or Country) St.Marys Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Johnson.(C)wife.

(Address) Pasadena A.A.Co.Md.

15-

Filed....., 191.....

Registrar.

SEP 19 1917 HARRY C. ANDREWS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 17th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M Reinhardt M. D.
(Coroner)

Sept.18,1917. (Address) 1017 S.Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Pasadena A.A.Co.Md.

19-PLACE OF BURIAL OR REMOVAL, Magothy a.a.co.md

DATE OF BURIAL, Sept 19th 1917

20-UNDERTAKER Joseph a Farrell

ADDRESS 2319 Division St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8564

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 260 Calvin ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Queen

(Residence in Baltimore: No. 260 Calvin St.; — yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	married

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
53 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer) general housework

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Harris

(Address) 260 Calvin St

15-

Filed ....., 191.....

Registrar.

SEP 19 1917

HARRY C. ANSLOW

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 16, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1917, to Sept. 16 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Malvular Heart Disease

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert F. Green M. D.

Sept. 17, 1917. (Address) 120½ Asquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept 19, 1917
20-UNDERTAKER Charles B. Jones	ADDRESS 230 Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8565

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2541 Florence ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Matthews

(Residence in Baltimore: No. 2541 Florence St.; ~ yrs., ~ mos., ~ ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 070 .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Spencer

(Address) 611 Druid Hill Ave

15-

SEP 19 1917 HARRY C. ANDREWS

Filed ..... 191 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Sept 16 1917, that I saw h~ alive on Sept 15 1917, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of L Lung

Hemorrhage from L Lung

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Tumor

(Duration) yrs. 2 mos. 1 ds.

(Signed) D. J. Gallivan M. D.

Sept 17 1916. (Address) 708 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Sept 20 1917.

20-UNDERTAKER, Charles B. Jones

ADDRESS 235 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8566 — 104 ✓ — D 8566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403, S. Ann St.; 2 Ward) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albina B. Wisniewska

(Residence in Baltimore: No. 403. S. Ann. St; — yrs., 9 mos. 16 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOW, OR DIVORCED (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec 1, 1916 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 9 mos. 16 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bronislaw Wisniewski

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER Stanislawa Wisniewski

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislawa Wisniewski

(Address) 403 S. Ann St

15-

Filed SEP 19 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1917, to time of death 191..., that I saw h alive on Sept. 17 1917, and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(Duration) ...yrs. ...mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) G. F. Ries M. D.

Sept. 18, 1917. (Address) 24 Strathdene

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Sept. 20 1917
20-UNDERTAKER,	ADDRESS
William Fialkowski	1618 Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8567

CERTIFICATE OF DEATH.

81 ✓ D 8567

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Exeter St ST.; 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Bass (Bass)

(Residence in Baltimore: No. 120 S. Exeter St St.; 27 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1844 (Year)

7-AGE, 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Meier

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto St

15- SEP 19 1917

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 2 1917, to Sept 18 1917, that I saw her alive on Sep 18 1917, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 7 yrs. mos. ds.

(Signed) M. L. Baylin M. D.

Sept 19, 1917. (Address) 727 Airpark

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 9/19, 1917.

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 8563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8563

CERTIFICATE OF DEATH.

REGISTERED No. C 1024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Schwartz

(Residence in Baltimore: No. 32 S. Exeter St.; Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. February (Month) 14 (Day), 1917 (Year)

7-AGE, yrs. 7 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Isadore Schwartz

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Ethel London

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry B. Conrad

(Address) Johns Hopkins Hosp.

15-

SEP 19 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 6 191 7, to Sept. 18 191 7, that I saw him alive on Sept. 18 191 7, and that death occurred, on the date stated above, at 3 20 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion

(Duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Conrad M. D.

Sept. 18, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 1 mos. 12 ds. In the State 4 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 32 S. Exeter St.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Int. Assn.

DATE OF BURIAL. 9.21., 191..

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 8569 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital 21 REGISTERED NO. C 108

CITY OF BALTIMORE: (NO. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wegweith

(Residence in Baltimore: No. 1308 Sergeant St.; 23 yrs. 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Aug 4th (Month) (Day), 1894 (Year)

7-AGE. 23 yrs. 1 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter's

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER William Wegweith

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm Wegweith

(Address) 1308 Sergeant St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 19 1917, that I saw h[illegible] alive on Sept 19 1917, and that death occurred, on the date stated above, at 12.35 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis

Sept 17 (Duration) .... yrs. .... mos. 4 ds.

CONTRIBUTORY (Secondary) ?

Appendicitis (Duration) .... yrs. .... mos. 1 ds.

(Signed) J. H. Richter M. D.

Sept 19 1917. (Address) Franklin Sq. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 2 ds. In the State 24 yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1308 Sergeant St.

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. Sept 21, 1917

20-UNDERTAKER John Heavan Son

ADDRESS 907 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8570

CERTIFICATE OF DEATH.

81 D 8570

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 10 ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Emory

(Residence in Baltimore: No. Little Sisters of the Poor St.: 1 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1853
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, Hathery Emory

11-BIRTHPLACE OF FATHER (State or Country), dont Known

12-MAIDEN NAME OF MOTHER dont Known

13-BIRTHPLACE OF MOTHER (State or Country), dont Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

SEP 19 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No Record 191, to 191, that I saw her alive on Sept 16 191 7, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro Cerebrale

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 18, 191 7 (Address) 1123 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 6 mos. 1 ds. | In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL, Holy Cross | DATE OF BURIAL, Sept 19, 191 7

20-UNDERTAKER H. C. Wedefeld | ADDRESS 914 Pennsylvania Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8571 ✓ D 8571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Little Sisters of the Poor St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Witzenburger

(Residence in Baltimore: No. Little Sisters of the Poor St.; 40 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Unknown, 1850 (Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Witzenburger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret

13-BIRTHPLACE OF MOTHER (State or Country), don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- SEP 19 1917 MARY C. ANDREWS REGISTRAR OF VITAL STATISTICS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Nov~~ 1917, to ....., 191...., that I saw h~~er~~ alive on Sept. 16 1917, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

..... Duration

Tuberculosis disease of hand

.....

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. A. Bowen M. D.

Sept 18, 1917. (Address) 1133 Vallon St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. mos. ds. In the State 40 yrs. mos. ds.

Where was disease contracted if not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Sept. 19, 1917

20-UNDERTAKER H. C. Wedefeld ADDRESS 914 Greenmount Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D. 8572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 8572

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Thames ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Schmidt

(Residence in Baltimore: No. 1616 Thames St.: 6 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... Dec 26 1915
(Month) (Day) (Year)

7-AGE, ... 1 yrs. 8 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(h) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Lonska

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Schmidt

(Address) 1616 Thames St

15-

SEP 19 1917

Filed....., 191.....

HARRY C. ANELLO
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 18 1917, that I saw h[illegible] alive on Sept 18 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

Primary (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

(Signed) C W J Rosamond M. D.

Sept 19 1917. (Address) 600 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept 19 1917.

20-UNDERTAKER H. Sanders & Son — ADDRESS 1710 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8573

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Karns

(Residence in Baltimore: No. Aberdeen Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Solicitor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Pennsylvania.

PARENTS.

10-NAME OF FATHER, John Karns

11-BIRTHPLACE OF FATHER (State or Country), Pa,

12-MAIDEN NAME OF MOTHER Martha Ashbaugh.

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Record.

(Address)

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15 1917, to Sept. 16 1917, that I saw h[illegible] alive on Sept. 16 1917, and that death occurred, on the date stated above, at 1734 m.

The CAUSE OF DEATH* was as follows:

Carcinoma S. Colon.

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction (Duration) yrs. mos. 4 ds.

(Signed) Dr. E. Ziter M. D.

....., 191... (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Aberdeen Md

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Sept. 17 1917.

20-UNDERTAKER W J Jackson ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8574

D 8574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Sharp ST.; 27 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen B. Showacre

(Residence in Baltimore: No. 627 E Pratt St.; Life yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Oct 4, 1870 (Month) (Day) (Year)

7-AGE, 46 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas S. Showacre

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Emma Keech

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Mary Showacre

(Address) 627 E Pratt St

15-

Filed....., 191... SEP 19 1917 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1917, to Sept 16 1917, that I saw h'r alive on Sept 15 1917, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Intestine (Which from important history I judge to have had a duration of about
..... (Duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Tuberculosis of Lung not very active (Duration) ? yrs. mos. ds.
(Signed) Geo. T. Kemp M. D.
Sept 18, 1917. (Address) St. James Apts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	Sept 18, 1917
20-UNDERTAKER	ADDRESS
W. J. Tuckerman & Sons	Inc

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8575

CERTIFICATE OF DEATH.

D 8575

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Seth T. Rigby

(Residence in Baltimore: No. Same St.; yrs., mos. ds.)

Same as Hospital

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 4 (Day), 1852 (Year)

7-AGE, 65 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

079 076

9-BIRTHPLACE, (State or Country), Utah

PARENTS.

10-NAME OF FATHER, Seth Rigby

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Cook

13-BIRTHPLACE OF MOTHER (State or Country), Utah

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. L. Smith

(Address) Johns Hopkins Hospital

15-

SEP 13 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 17 1917, to Sept 18 1917, that I saw h[illegible] alive on Sept 18 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy (benign)

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Bunn M. D.

Sept 19 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1810 Main St Salt Lake City Utah

19-PLACE OF BURIAL OR REMOVAL, Salt Lake City Utah

DATE OF BURIAL, Sep. 19..., 1917.

20-UNDERTAKER Allied Funeral

ADDRESS 221 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8576

D 8576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N Bruce St ST.; 19 WARD)

REGISTERED NO. C 105

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Coleman

(Residence in Baltimore: No. 714 N Bruce St. St.; 13 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Oct 1 (Month) (Day), 1844 (Year)

7-AGE. 69 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Minister
(b) General nature of industry, business, or establishment in which employed (or employer). of M E

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John Coleman

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. William Coleman

(Address) 1604 Brexbury St.

15-

Filed....., 191....

Registrar.

SEP 1 1917

HARRY C. GRIFFITH
Clerk Records Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 191 7, to Sept 17 191 7, that I saw h alive on Sept 17 191 7, and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Dysentery

Duration: 7 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) yrs. mos. 14 ds.

(Signed) F. E. Lurz M. D.

Sept 18, 191 7 (Address) 1310 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodwell Cem. Washington DATE OF BURIAL, Sept 19 191 7.

20-UNDERTAKER Wilbur Brown ADDRESS 901 Hollins St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8577.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55 D 8577.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Ramsay ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wellmer Gaterman.

(Residence in Baltimore: No. 1215 Carroll St. St. [redacted] yrs., 8 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. Jan. 10, 1907. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
10 yrs. 8 mos. 7 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Louis Gaterman

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia, Pa.

12-MAIDEN NAME OF MOTHER Emma Wellmer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Gaterman

(Address) 1215 Carroll St.

15-

Filed....., 191.....

Registrar.

SEP 20 1917 HARRY C. ANDREWS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 17, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep. 8 1917, to Sept. 17, 1917, that I saw h him alive on Sept. 17, 1917, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Meningitis.

(Duration) Unknown

CONTRIBUTORY (Secondary) Pneumonia, lobar

and Cateria (Duration) yrs. mos. 9 ds.

(Signed) Albert J. Chambers M. D.

Sept. 18, 1917. (Address) 1017 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Sept 20, 1917.

20-UNDERTAKER J. B. Kupfrian — ADDRESS 2236 Fredk Av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8573

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N. Montford Av ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Staak

(Residence in Baltimore: No. 122 N. Montford Av. St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow.

6-DATE OF BIRTH, Oct 5, 1846
(Month) (Day) (Year)

7-AGE, 71 yrs. 7 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House work. no
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Effrich

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Staak

(Address) 623 N. Luzerne Av.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1916, to Sep 17 1917, that I saw h[er] alive on Sep 17 1917, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus.

(Duration) 10 yrs. 10 mos. 21 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis Vogt M. D.

Sep 17, 191 7 (Address) 2601 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Sept. 20 191 7.

20-UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wolfe St

SEP 19 1917 Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DO INK—THIS IS A PERMANENT RECORD

D 8579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+175

D 8579

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Brown Coln

(Residence in Baltimore: No. 719 S. Bouldin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... May (Month) ..... 2 (Day), 1913 (Year)

7-AGE, ... 4 yrs. 1 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... no

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Albert Brown Coln

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Dampson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mother

(Address) 719 S. Bouldin

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) ..... 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Intestinal Injuries

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner.)

..... 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	Sept. 19, 1917
20-UNDERTAKER Lilly & Zile	ADDRESS 403 E. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 8580

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Orchard St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Era Wilson

(Residence in Baltimore: No. 502 Orchard St.; Life yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1894 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wright Wilson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lillie Hatton

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Wilson

(Address) 502 Orchard St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Sept. (Month) 17 (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 14 1917, to Sept 17 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

..... (Duration) ..... yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (Duration) ..... yrs. 4 mos. 3 ds.

(Signed) Edward V. Ferguson M. D.

Sept 17, 1917. (Address) 418 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 19th 1917

20-UNDERTAKER: Samuel Kemsley — ADDRESS: 578 N Ridge

SEP 1 1917 HARRY J. McLEWS Burial Permits Clerk

Spec.—5-19-13—M. & T.—500 Bks.

D 8581

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8581

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Moore

(Residence in Baltimore: No. 806 George Av St.; 48 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....

8 96 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Moore

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Charlotte Tasker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Brent

(Address) 806 Geo Ave

15-

SEP 19 1917 MARY C. ARMIGER

Filed ..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5 1917, to Sept. 19 1917, that I saw h.. alive on Sept. 16 1917, and that death occurred, on the date stated above, at 7 3/4 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) 1 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. D. Thiel M. D.

Sept. 19 1917 (Address) 206 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Sept 22 1917

20-UNDERTAKER Simon H. Cooper Son ADDRESS 1100 Mosher

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8582

CERTIFICATE OF DEATH.

28

D 8582

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 W Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Dorsey (Duppin)

(Residence in Baltimore: No. 717 W Mulberry St.; 5 yrs., ... mos., ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: Unknown, ... (Month) ..... (Day) 1 (Year)

7-AGE: 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mat
(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeper

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Dorsey

(Address) 717 W Mulberry

15-

SEP 19 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1917, to Sept 17 1917, that I saw her alive on Sept 16 1917, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Haemorrhage immediate

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm E Burton M. D.

Sept 17, 1917. (Address) 962 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: W. Glen

DATE OF BURIAL: Sept 20, 1917

20-UNDERTAKER: Sam'l H Chase & Son

ADDRESS 1400 Madison

Spec.—8-24-14—M. & T.—2000 Blks.

(Robert Thrower)

D 8583

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 8583

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Thrower

(Residence in Baltimore: No. 1527 Jefferson St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	a. a.	Married

6-DATE OF BIRTH, Nov. 12, 1842
(Month) (Day) (Year)

7-AGE, 74 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER. Robert Thrower

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ellen Ruff

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Thrower, Jr.

(Address) 1527 Jefferson St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1917, to Sept. 18 1917, that I saw h[illegible] alive on Sept. 17, 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

..... (Duration) ...yrs. 8 mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (Duration) ...yrs. 8 mos. ...ds.

(Signed) E. K. Johnson M. D.

9/18 1917 (Address) 1526 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery — DATE OF BURIAL, Sept 21st, 1917

20-UNDERTAKER Chas G Bailey — ADDRESS 1727 Jefferson St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARY C. ANDREWS
SEP 20 1917
DEPUTY REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8581 — 8 D 8581

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1737 Homestead St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aubrey Pearre Upton

(Residence in Baltimore: No. 1737 Homestead St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) Janu 16 (Day), 1917 (Year)

7-AGE, ... yrs. 8 mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo W. Upton

11-BIRTHPLACE OF FATHER (State or Country), Aaco Md

12-MAIDEN NAME OF MOTHER Addie L Draper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Upton

(Address) 1737 Homestead

15-

SEP 19 1917 HARRY C. ARLOW Registrar of Vital Statistics

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 18 1917, that I saw h[im] alive on Sept 18 1917, and that death occurred, on the date stated above, at 11.01 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Wm Pearre M. D.

Sept 19, 1917 (Address) 5 E Preston

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, (Sept. 19, 191..)

20-UNDERTAKER H. Sherwood — ADDRESS Norton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+79 D 8585

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Hospt. St.; 4 Ward) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Graf

(Residence in Baltimore: No. S.S. War King St.; Unknown yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Yellow

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Unknown.

6-DATE OF BIRTH, ... (Month) — (Day) — 18.77. (Year)

7-AGE, 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work British Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), China

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) British Consulate

(Address) Munsey Bldg

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16., 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 16 1917, that I saw him alive on Sept 16 1917, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degen.

..... (Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac

dilation (Duration) Unknown yrs. mos. ds.

(Signed) B. R. Brumbaugh M. D.

Sept. 16 1917. (Address) Union Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1 ds. In the State Unknown. yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence B.S.S. War King.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Sept. 19..., 191.7.

20-UNDERTAKER J. P. Bloch — ADDRESS 1023 Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8586 D 8586

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2660 Presbury St.; St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fay E. Jesson

(Residence in Baltimore: No. 2660 Presbury St.; St.: ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...Mar.... (Month) ....7.... (Day) ....1881.... (Year)

7-AGE, ...36.... yrs. ....6.... mos. ....11.... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ben F. Tall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Tilton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice M. Hubbard

(Address) 2660 Presbury St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 15 1917, to Sept 18 1917, that I saw h— alive on Sept 18 1917, and that death occurred, on the date stated above, at 1 C. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary T. B.

(Duration) ....yrs. 10 mos. ....ds.

(Signed) A T Reis M. D.

Sept. 19, 1917. (Address) 24 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cambridge Md	Sept. 21, 1917.
20-UNDERTAKER	ADDRESS
Lowe Cook	502 E York

Via A Ora to Jas Jesson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8587.

CERTIFICATE OF DEATH.

28 D 8587.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Harford Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Faubrup

(Residence in Baltimore: No. 2306 Harford Ave St.; 5 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, April (Month) 15th (Day) 1836 (Year)

7-AGE,	If LESS than 1 day,
81 yrs. 5 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H M Sadler

(Address) 2102 Eastern Ave

15-

SEP 19 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14th 1917, to Sept 18th 1917, that I saw h[illegible] alive on Sept 18th 1917, and that death occurred, on the date stated above, at 4-10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) about 6 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Fair M. D.

Sept 19, 1917. (Address) 17 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Prospect Hill-Towson	Sept 20, 1917

20-UNDERTAKER	ADDRESS
Wm Cook	502 E. Mall

Spec.—8-24-14—M. & T.—2000 Bks.

D 8583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 444 East 22nd ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Cook

(Residence in Baltimore: No. 444 East 22nd St.; 41 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 4 (Day), 1847 (Year)

7-AGE, 70 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): H.W. 0

9-BIRTHPLACE, (State or Country), Jersey City

PARENTS.

10-NAME OF FATHER, William Tinson

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert E. Cook

(Address) 444 East 22nd

15-

SEP 19 1917

Filed....., 191....., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 18th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 4 1917, to September 18 1917, that I saw h er alive on September 18 1917, and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) ....yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. mos. 5 ds.

(Signed) P. E. Tilley M. D.

9/19/17, 191.. (Address) 502 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Sept 21, 1917

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Dr Tilley East North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8589

CERTIFICATE OF DEATH.

150 D 8589

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 S. Calhoun St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert C. Warren

(Residence in Baltimore: No. 300 S. Calhoun St.; 1 yrs., 7 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb. (Month) 7 (Day), 1916 (Year)

7-AGE, 1 yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter T. Warren

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Flora Pohlhaus

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter T. Warren

(Address) 300 S. Calhoun St.

15-

Filed....., 191.....

Registrar.

SEP 19 1917 ROBERT L. KRAUTER CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1917, to Sept 18 1917, that I saw him alive on Sept 18 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) Life time ds.

CONTRIBUTORY (Secondary) Acute L. Bronchitis

(Duration) 3 wks. 3 mos. 3 ds.

(Signed) Henry E. Cole M. D.

Sept 19, 1917. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Pk

DATE OF BURIAL, Sept 20, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 E North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8590

CERTIFICATE OF DEATH.

104 D 8590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Shakespeare St.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stefan Gorski

(Residence in Baltimore: No. 1603 Shakespeare St.; ..... yrs., 7 mos. 11 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Feby 7, 1917. (Month) (Day) (Year)

7-AGE, ... yrs. 7 mon. 11 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Gorski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Katherine Dominak

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gorski.

(Address) 1603 Shakespeare St

15-

Filed ....., 191.....

Registrar.

SEP 19 1917 ROBERT B. KRAUTER BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1917 to Sept 18 1917, that I saw h— alive on Sept 18 1917 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Collitis.

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Cardio Pulmonary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Adam M. D.

Sept 19, 1917 (Address) 1208 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Sept. 20, 1917.

20-UNDERTAKER W. J. Radomski — ADDRESS 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8591 — 104 — D 8591

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1815 Thames ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdalene Buczkowska

(Residence in Baltimore: No. 1815 Thames St. yrs. 9 mos. 21 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Nov. (Month) 25. (Day), 1916. (Year)

7-AGE: yrs. 9 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Victor Buczkowski.

11-BIRTHPLACE OF FATHER (State or Country): Poland.

12-MAIDEN NAME OF MOTHER: Julia Winiarski.

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Buczkowski

(Address) 1815 Thames St.

15-

SEP 19 1917 ROBERT E. KRAUTH

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept. (Month) 18, 1917 (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Sept 18 1917, that I saw h[er] alive on Sept 18 1917, and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis Colitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

(Signed) W. J. Rahm M. D.

Sept 19, 1917 (Address) 1200 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Sept. 20, 1917.

20-UNDERTAKER: W. F. Sadowski — ADDRESS: 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8592 150 D 8592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lanvale ~~Fairfield~~ St.; ~~4~~ (WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Bland

(Residence in Baltimore: No. 2 St.; ....yrs.,, mos. 1 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W	

6-DATE OF BIRTH, 9 (Month) 15 (Day) 1917 (Year)

7-AGE, ...yrs....mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Bland

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Evelyn Britt

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) ....

15-

Filed SEP 19 1917 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-15 1917, to 9-17 1917, that I saw h[illegible] alive on 9-15 1917, and that death occurred, on the date stated above, at 5:2[illegible] m.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

.... (Duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) ....

.... (Duration) ....yrs....mos....ds.

(Signed) [signature] M. D.

9-19, 1917. (Address) Lanvale & [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL SEP 19 1917

SEP 19 1917 ROBERT R. KRAUTER Commissioner of Health.

BURIAL PERMIT

5168

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

621

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8593

CERTIFICATE OF DEATH

1 D 8593

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 645 W. Fayette St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Arthur Riland Deets

(Residence in Baltimore: No. 645 W. Fayette St.: yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug. (Month) 31, (Day) 1917 (Year)

7 AGE: ..... yrs. 1 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Arthur Deets

11 BIRTHPLACE OF FATHER (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Hettie Saunders

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 18, (Day) 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1917, to Sept 18 1917 that I saw him alive on Sept. 18, 1917 and that death occurred, on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Marasmus

Malnutrition

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry A. Weinter jr M. D.

9/18/, 1917 (Address) 72x W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL: SEP 19 1917, 191....

20 UNDERTAKER: ROBERT R. KRAUTER

ADDRESS

SEP 19 1917 Commissioner Health

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. —THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8591

CERTIFICATE OF DEATH.

104 D 8591

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 W. Hamburg St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Velmar Spriggs (C)

(Residence in Baltimore: No. 211 W. Hamburg St. St.; yrs. 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single.

6-DATE OF BIRTH, November 8th. 1916., / (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 10 mos. 10 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Spriggs (C)

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Lottie Pinckney. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Spriggs (C)

(Address) 211 W. Hamburg St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chloera Infantum.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Sept. 19, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn St	Sept 20 1917
20-UNDERTAKER	ADDRESS
C. E. Brown & Son	1 S. Monroe

SEP 19 1917 ROBERT R. CRAUTEN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1157 D 8595

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. City Jail ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gotlold Preuse

(Residence in Baltimore: No. 3204 Winfield Ave. St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Baltimore Md.

15- SEP 19 1917 ROBERT D. KRAUTER

Filed....., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strangulation
while insane

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hanging

(Duration) yrs. mos. ds.

(Signed) W. J. Riley M. D.
(Coroner.)

Sept 19, 1917. (Address) 1635 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept. 20, 1917

20-UNDERTAKER J. B. Cook — ADDRESS 1003 Madison St

Spec.—5-19-13—M. & T.—500 Blks.

D 8596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8596

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mamie Elizabeth Ford

(Residence in Baltimore: No. 104 S. Gilmor St.; 35 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb. (Month) 10 (Day), 1855 (Year)

7-AGE, 63 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, William Glascock

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Matilda Low

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. L. M. Ford

(Address) Round Heights Rd.

15- SEP 19 1917 ROBERT B. KRAUTER Registrar.
Filed....., 191.... Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 12 1917, to Sept 18 1917, that I saw her alive on Sept 18 1917, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

L. V. Endocarditis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

(Duration) yrs. mos. 6 ds.

(Signed) Lewis M. Ford M. D.

Sept 19, 191.. (Address) 735 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Sept 21, 191..
20-UNDERTAKER Wesley J. Cook	ADDRESS 1003 W. Baltimore St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8597.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8597.

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1620 N. Dallas St. 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Lockley

(Residence in Baltimore: No. 1620 Dallas St.; 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Black

5-~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: ..... (Month) ....., 1 ..... (Day) ..... (Year)

7-AGE: 57 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer, day
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Cockeysville, Md.

PARENTS

10-NAME OF FATHER: Zachariah Lockley

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Emily -

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Lockley

(Address) 1620 N. Dallas St.

15-

Filed SEP 19 1917, 191 ..... ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1917, to, Sept. 15, 1917, that I saw h[illegible] alive on Sept. 15, 1917, and that death occurred, on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis
Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Myocarditis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed), Knight Forsythe M. D.

Sept. 18, 1917 (Address) 241 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Auburn Cem | DATE OF BURIAL: Sept 20th, 1917

20-UNDERTAKER: Harry A Vodery | ADDRESS: 1725 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 E. Clement ST.; 24 WARD) REGISTERED No. C

2-FULL NAME John Holzschuh

(Residence in Baltimore: No. 1525 E. Clement St.; 33 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. (Month) 12 (Day), 1857 (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 9 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sexton of
(b) General nature of industry, business, or establishment in which employed (or employer): Church of

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Holzschuh

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Holzschuh

(Address) 1525 E. Clement St.

15-

Filed....., 191.....

SEP 19 1917 ROBERT B. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 17 1917, that I saw him alive on Sept 17 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate
Cirrhosis of Liver 8

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 7 ds.

(Signed) Jas A O'Donnell M. D.

Sept 19, 1917 (Address) 101 E West St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 20 1917
20-UNDERTAKER M. J. Flynn	ADDRESS 1425 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8599

D 8599

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1924 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Chapman

(Residence in Baltimore: No. 1924 McCulloh St.; 4 yrs., mos. ds.)

31 yrs in City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 6, 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), St Marys Co Md

PARENTS.

10-NAME OF FATHER, Charles Chapman

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co Md

12-MAIDEN NAME OF MOTHER Charlotte Beau

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Chapman

(Address) 1924 McCulloh St. Wife

15-

SEP 19 1917

ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 15 1917, and that death occurred, on the date stated above, at 12 Jan m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cerebral Hemorrhage

2nd attack (Duration) yrs. mos. 2 hours ds.

CONTRIBUTORY, Nephritis
(Secondary)

..... (Duration) yrs. 6 mos. ds.

(Signed) Wm. H. Wright M. D.

Sept 17, 1917. (Address) 1209 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 20, 1917

20-UNDERTAKER Samuel T Kenney — ADDRESS 578 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8600 D 8600

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Volz

(Residence in Baltimore: No. 514 S. Broadway St.; Life yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Sept 2, 1871 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
46 yrs. mos. 17 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Glickman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amalia Albert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Volz

(Address) 514 S. Broadway

15-

Filed....., 191.....

Registrar.

SEP 20 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 17 1917, and that death occurred, on the date stated above, at [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Uraemia -
(Following Operation).
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Incarcerated Hernia
(Duration)....yrs....mos....ds.

(Signed)..... M. D.

Sept 19, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State 46 yrs. ....mos. [illegible] ds.

Where was disease contracted, if not at place of death?

Former or usual residence 514 S. Broadway

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Sept 22, 1917
20-UNDERTAKER H. Sanderstorf	ADDRESS 1700 Eut St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 8601

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 S. Decker Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Carrow

(Residence in Baltimore: No. 835 S. Decker Ave St.; 6 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. 4th, 1880 (Month) (Day) (Year)

7-AGE, 37 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

800 00

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER. William F. Carrow

11-BIRTHPLACE OF FATHER (State or Country). Delaware

12-MAIDEN NAME OF MOTHER Margaret Endfield

13-BIRTHPLACE OF MOTHER (State or Country). Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Carrow

(Address) 835 S. Decker Ave

15-

SEP 20 1917 HARRY O. ANDREWS

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1. 1917, to Sept 18 1917, that I saw him alive on Sept 17 1917, and that death occurred, on the date stated above, at 8 1/2 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

Bronchopneumonia (Duration) yrs. mos. 7 ds.

(Signed) W. F. Burke M. D.

Sept 19, 1917. (Address) W. F. Burke

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Delaware City Del. DATE OF BURIAL, Sept 21st, 1917

20-UNDERTAKER H. Sander & Sons ADDRESS 1710 E.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8602

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 ✓ D 8602

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 257 W. 31 St St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna. Engle

(Residence in Baltimore: No. 257 W. 31 St.)

St.: yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec 21, 1848 (Month) (Day) (Year)

7-AGE: 68 yrs. 8 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Pa

PARENTS

10-NAME OF FATHER: Edward McCulloh

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Elvia Gibson

13-BIRTHPLACE OF MOTHER (State or country): Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Kennedy

(Address) 257 W. 31st St

15

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 18 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1917, to Sept 18, 1917, that I saw her alive on Sept 18, 1917, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Gastric Carcinoma

(Duration) 2 yrs. 8 mos. ds.

(Signed) Isaac H. Crossen M. D.

Sept 18, 1917 (Address) 1438 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Parkton Pa. DATE OF BURIAL: Sept 21, 1917

20-UNDERTAKER: A. S. Mawhood ADDRESS: 2538 Fallsd

SEP 20 1917 HARRY C. ANDREWS Burial Permit

D 8603

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 ✓ D 8603

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1203 S Hanover St 22 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Raymond Lee Nesline

(Residence in Baltimore: No. 1203 S Hanover St St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 10, 1917 (Month) (Day) (Year)

7 AGE: yrs. 6 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: John F. Nesline

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lola A Smoot

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lola A Nesline
(Address): 1203 Hanover St

15 Filed SEP 20 1917, 191 Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 18 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1917, to Sept 18, 1917, that I saw h[illegible] alive on Sept 17, 1917, and that death occurred, on the date stated above, at 3-a m.
The CAUSE OF DEATH* was as follows:

Malnutrition

Contributory (SECONDARY) Exhaustion (Duration) yrs. 2 mos. ds

(Duration) yrs. mos. 7 ds.

(Signed) G E Dunton M. D.

9/18, 1917. (Address) 206 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Sept 20, 1917

20 UNDERTAKER: A+60 — ADDRESS: Whyte & Sons Inc 1428 Pitts St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8601

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Scott ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles M Johnson

(Residence in Baltimore: No. 626 Scott St.; ..... yrs., 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	single

6-DATE OF BIRTH, April 22, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 4 mos. 28 ds.	.... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Alonzo Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Florence Duvall

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alonzo Johnson (Father)

(Address) 626 Scott St.

15-

Filed SEP 20 1917, 191.....

MARY C. ANDREWS
BURIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 19 1917, that I saw h[illegible] alive on Sept 18 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Morley Stevens M. D.

Sept 19 1917 (Address) 626 Scott ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept. 19, 1917.
20-UNDERTAKER	**ADDRESS**
Armstrong Denny Co.	715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8605

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8605

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Jackson St. 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doratha Elizabeth Klein

(Residence in Baltimore: No. 1603 Jackson St.; 60 yrs., — mos., — ds.) about

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, July 20 (Month) (Day), 1840 (Year)

7-AGE, 77 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Eisple

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Fiscel

(Address) 1603 Jackson St.

15-

SEP 20 1917 HARRY C. ANDREWS

Filed....., 191.... Registrar of Vital Statistics of Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 19 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 19 1917, that I saw her alive on Sept 19 1917, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Uremic Nephritis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) B. Sidney A. Strutt M. D.

Sept 19, 191... (Address) 1131 E. Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Cedar Hill DATE OF BURIAL. Sept 21., 191.7

20-UNDERTAKER Sam. Weber & Son ADDRESS 1603 Edmondson Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8606

CERTIFICATE OF DEATH.

40 ✓ D 8606

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 St Mathias St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R. Levy

(Residence in Baltimore: No. 1230 St Mathias St St.; 20 yrs.. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 184?
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levy

(Address) 1411 E Balto St

15- SEP 20 1917 Filed....., 191.....
HARRY O. ANDREWS
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 191✓, to Sept 20 1917, that I saw h✓ alive on Sept 19 1917, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Obstruction pylorus and stomach
due to malignant growth

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Aortic + Mitral Regurg. Nephritis unknown

(Duration) yrs. mos. ds.

(Signed) A Tilis M. D.

Sept 20, 1917. (Address) 24 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Benevolent | DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER Southern Jack Levin | ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 8697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 ✓ D 8697

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Griffith Ct ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Poggioli

(Residence in Baltimore: No. 720 Griffith ct St.; ..... yrs., 4 mos. 25 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Apr. (Month) 24 (Day), 1917 (Year).

7-AGE, ... yrs. 6 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Anthony Poggioli

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Janey Poggioli

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Poggioli

(Address) 720 Griffith Ct

15- SEP 20 1917

Filed ....., 191.... HARRY C. ANDREWS

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 19th (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 19 1917, that I saw h[illegible] alive on Sept 19 1917, and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

..... Intestitis .....

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) [illegible] M. D.

Sept. 20, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincent	Sept. 20, 1917.
20-UNDERTAKER	ADDRESS
Wendell Lippel & Son	332 S. Bond St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8608

CERTIFICATE OF DEATH.

D 8608

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S. Bond. St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wieslaw. Klimek

(Residence in Baltimore: No. 832 S. Bond St. St.; 1 yrs., mos. 18 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. ~~Single~~ (write)

6-DATE OF BIRTH. Sept (Month) 1 (Day), 1916 (Year)

7-AGE. 1 yrs. mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country). Baltimore.

PARENTS.

10-NAME OF FATHER. Wiktor Klimek

11-BIRTHPLACE OF FATHER (State or Country). Russian poland

12-MAIDEN NAME OF MOTHER Eva. Skowronska

13-BIRTHPLACE OF MOTHER (State or Country). Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wiktor Klimek

(Address) 832 S. Bond St.

15-

Filed SEP 20 1917, 191.... HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 191 7, to Sept 19 191 7, that I saw h[illegible] alive on Sept 19 191 7, and that death occurred, on the date stated above, at 9 30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary Probably Due to Measles (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Colic Cholera Infantum

(Duration) ....yrs. mos. 1 ds.

(Signed) W. [illegible] M.D.

Sept 19, 191 7 (Address) 1205 E. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary DATE OF BURIAL, Sept 20 191 7

20-UNDERTAKER M. Fallowski ADDRESS 1618 Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

8609

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8609

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Dallas St.; .....WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Gropenski

(Residence in Baltimore: No. 417 S. Dallas St. St.: 1 yrs., mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Aug. (Month) 20 (Day), 1916 (Year)

7-AGE, ... 1 yrs. — 30 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Peter Gropcinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Tienyzorka

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Gropcinski

(Address) 417 S. Dallas St.

15-

Filed SEP 20 1917, 191.....

HENRY C. ANDREWS
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 191 , to Sept 18 191 ,

that I saw h — alive on Sept 19 191 ,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

..... Acute Intestinal .....

.....

.....

..... (Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. Steudtan M. D.

Sept 19 191.. (Address) 16 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sept. 20 191.7.

20-UNDERTAKER Jacob Fialkowski

ADDRESS 428 S. Bond St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17
43

D 8610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 8610

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 730 N. Bruce ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Harris.

(Residence in Baltimore: No. 730 N. Bruce St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Harris

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Carrie Fillden

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife

(Address) 730 N. Bruce

15-

Filed SEP 20 1917, 191.... HARRY C. ARGERS

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Sept. 20, 191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept. 20, 19..

20-UNDERTAKER Edward Ringgold

ADDRESS 1403 E. Baltimore

Spec.—8-21-14—M. & ...—2000 Blks.

D 8612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8612

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1342 Presstman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm E. Neal

(Residence in Baltimore: No. 1342 Presstman St.; ...yrs,...mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	Colored	Baby

6-DATE OF BIRTH, Sept 17, 1916.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Neal

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ella Gray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Neal

(Address) 1342 Presstman

15-

Filed SEP 20 1917, 191.... HARRY C. ...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/12 191.7, to 9/18 191.7, that I saw h... alive on 9/17 191.7, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Colon Pneumonia

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secoudary) ...

(Duration)...yrs...mos. 1 ds.

(Signed) ... M. D.

9/18, 191.7 (Address) 2139 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Sept 20 1917
20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 N Bway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hosp. 9 × 109 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Ende

(Residence in Baltimore: No. Franklin ave Belair Rd and St.; 22 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 2, 1869
(Month) (Day) (Year)

7-AGE. 48 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Julius Figon

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Ende

(Address) Franklin Ave Belair Road

15-

SEP 20 1917

Filed....., 191.....

HARRY D. LANDIS
DEPUTY REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 19 1917, that I saw h & K alive on Sept 19 1917, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

Nephritis

Tuberculosis Pulmonalis (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) yrs. mos. ds.

(Signed) Myles B. Gradwohl M. D.

Sept 19, 191.. (Address) St Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Franklin Ave Belair Road

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 21, 1917

20-UNDERTAKER Williams Cook — ADDRESS 507 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓

D 8613

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 Lanman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel M Michel

(Residence in Baltimore: No. 1838 Lanman St.; Life yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) infant

6-DATE OF BIRTH, April th. 11 1914 (Month) (Day) (Year)

7-AGE, 3 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Nan

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thomas Michel

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Randell

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Michel

(Address) 1304 N. Bruce St

15-

SEP 20 1917

Filed....., 191... HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917 (Month) (Day) (Year)

17-✓ I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 18 1917, that I saw him alive on Sept 16 1917, and that death occurred, on the date stated above, at 12a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Lungs and Heart

(Duration) yrs. 2 mos. 5 ds.

(Signed) D. W. Kennedy M. D.

Sept ..., 191... (Address) 708 Ensor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, SEP 24 1917, 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8614 ✓ D 8614

CERTIFICATE OF DEATH.

REGISTERED NO. C 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Atterbury ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Smith.

(Residence in Baltimore: No. 205 Atterbury St.; 24 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) unknown (Day) (Year) 1885

7-AGE, 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James A Smith

11-BIRTHPLACE OF FATHER (State or Country), Springfield Ill

12-MAIDEN NAME OF MOTHER Alice Randall

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Smith

(Address) 15 Shapley St. New London Conn.

15-

Filed SEP 20 1917, 191 HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 18 1917, that I saw her alive on Sept 18 1917, and that death occurred, on the date stated above, at 2-17 pm.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Parenchymatous)

Antecedent (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. ds.

(Signed) John Harrison M. D.

9/20, 1917. (Address) 888 N. Lond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 9/20, 191

20-UNDERTAKER Samuel T Hawley

ADDRESS 578 W Balt

Spec.—8-24-14—M. & T.—2000 Bks.

D 8615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8615

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S. Ellwood ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Rice

(Residence in Baltimore: No. 723 S. Ellwood St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 30 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Rice

11-BIRTHPLACE OF FATHER (State or Country), Cumberland Md

12-MAIDEN NAME OF MOTHER Alice Jones

13-BIRTHPLACE OF MOTHER (State or Country), Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Rice

(Address) 723 S. Ellwood Ave

15-

Filed SEP 20 1917, 191.... HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Sept 19 1917, that I saw h[illegible] alive on Sept 19 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Acute Hlo Colitis

.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

.... (Duration) ....yrs. ....mos. 1 ds.

(Signed) L. A. Hartman M. D.

Sept 19, 191.. (Address) 1116 S. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Trinity cemetery

DATE OF BURIAL, Sept 22, 191..

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8616 **CERTIFICATE OF DEATH.** 104 ✓ D 8616

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2 ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Thompson

(Residence in Baltimore: No. St. Elizabeth's Home St.; yrs., 8 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	negress	S

6-DATE OF BIRTH, January (Month) 3 (Day), 1917 (Year)

7-AGE, ...yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Thompson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Lillian Walker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

ROBERT R. KRAUCH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Sept 17 1917, that I saw h[illegible] alive on Sept 17 1917, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Grante J. Ayd M. D.

Sept 19, 1917. (Address) 1957 E. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

SEP 19 1917 JOHNS HOPKINS HOSPITAL

SEP 20 1917 Burial Permit

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8617 **CERTIFICATE OF DEATH.** 120 D 8617

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilson Watson

(Residence in Baltimore: No. 444 Summerset St. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.)
male	Colored	Married

6-DATE OF BIRTH, ..., 1891.. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
26 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Sibley

(Address) Johns Hopkins Hosp.

15-

Filed....., 191.....

ROBERT B. KRAUTER
Registrar.

SEP 20 1917
Burial Permit Issued

JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept., 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1917, to Sept 16 1917, that I saw him alive on Sept 16 1917, and that death occurred, on the date stated above, at 11 a- m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 1? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) C. E. Bloomfield M. D.

Sept. 17., 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State yrs. mos. 25 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 444 Summerset St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, SEP 20 1917 ....., 191...
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8613

CERTIFICATE OF DEATH.

D 8613

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST.; ..... WARD)

2-FULL NAME Florence Langley.

(Residence in Baltimore: No. 740 Raborg St. St.; .....yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	black	single

6-DATE OF BIRTH, ... (Month) Unk (Day) ..... (Year) 1.....

7-AGE,	If LESS than 1 day,
12 .....yrs.....mos.....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Unk

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unk

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed SEP 20 1917, 191... ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 1917, to Sept 16 1917, that I saw h[illegible] alive on Sept 16 1917, and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Uncomplicated)

(Duration) .....yrs. .....mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) .....yrs. .....mos. .....ds.

(Signed) Wm. J. Fox M. D.

Sept 16, 1917.. (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. 21 days or .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 740 Raborg St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	SEP 1917, 191...

20-UNDERTAKER	ADDRESS

Commissioner of Health.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8619

CERTIFICATE OF DEATH.

28 D 8619

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 W. Baltimore 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward B. Stephens

(Residence in Baltimore: No. 2134 W. Baltimore St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 26, 1899
(Month) (Day) (Year)

7-AGE, 18 yrs. mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) in R.R. Paymasters Office

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Edward J. Stephens

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Anna M. Borryman

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw J. Stephens

(Address) 2134 W Balto St

15-

Filed SEP 20 1917, 191.... ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 7 1917, to Sept 18 1917, that I saw him alive on Sept 18 1917, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) E. J. Marx M. D.

Sept 19, 1917 (Address) 827 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery DATE OF BURIAL, Sept 21, 1917

20-UNDERTAKER Geo H Corby ADDRESS Balto & Payson Sts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 8620

CERTIFICATE OF DEATH

64 D 8620

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1702 N Bond St.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Washington Sullivan

(Residence in Baltimore: No. 1702 N Bond St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (~~Write the word~~)
Male	White	Married

6-DATE OF BIRTH February 22, 1840 (Month) (Day) (Year)

7-AGE 77 yrs. 6 mos. 27 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Dennis Sullivan

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Ann Henderson

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virgil E. Sullivan

(Address) Lansdowne Balto Co Md

15-

SEP 20 1917

Filed ....., 191.....

ROBERT E. KRAUTER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11, 1917, to, Sept 18 1917, that I saw him alive on Sept 18 1917, and that death occurred, on the date stated above, at 3 55 p m.

The CAUSE OF DEATH* was as follows;

Left Hemoghligia

(Duration) yrs mos. 8 ds.

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) yrs mos. 8 ds.

(Signed) R. P. Carman M. D.

Sept 18, 1917 [Address] 1702 N Caroline

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Western Cemetery

DATE OF BURIAL 9/21, 1917

20-UNDERTAKER Henry W. Maus & Son

ADDRESS 805 N. Caroline St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8621

HEALTH DEPARTMENT—CITY OF BALTIMORE

146

D 8621

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31) Joseph's (St.; 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph's Hospital (Guegdan)

(Residence in Baltimore: No. 1116 Brentwood Ave St.; 5 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. March (Month) 10 (Day), 1903 (Year)

7-AGE. 14 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). New York N. Y.

PARENTS.

10-NAME OF FATHER. Joseph Guegdan

11-BIRTHPLACE OF FATHER (State or Country). France

12-MAIDEN NAME OF MOTHER Elise Vincent

13-BIRTHPLACE OF MOTHER (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph's Guegdan

(Address) 1116 Brentwood Ave

15-

Filed SEP 20 1913 191

ROBERT B. KRAUTER
DEPUTY REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 19 (Day), 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1913, to Sept 19 1913, that I saw h[illegible] alive on Sept 19 1913, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows: Osteomyelitis

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Myles B. Hurley M. D.

Sept 19, 1913 (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 21 ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? [illegible]

Former or usual residence 1116 Brentwood Ave

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. Sept 22, 1913

20-UNDERTAKER Henry W. Weaver & Son

ADDRESS Forest Glen Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8622

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8622

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. S. W. Cor. Fulton Ave and Franklin ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. Armstrong

(Residence in Baltimore: No. Home of the Aged of the U. B. Church St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Feb 20, 1840 (Month) (Day) (Year)

7-AGE: 77 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: John Armstrong

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Susan Smith

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. R. Armstrong

(Address) Fulton & Franklin

15- SEP 20 1917 Filed ..... 191 ROBERT R. KRAUTH Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. 20, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1917, to Sept 20 1917, that I saw him alive on Sept 18, 1917, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. 6 mos. 6 ds

Contributory (SECONDARY) Cardiac Dilatation

(Duration) yrs. mos. Most ds

(Signed) Geo. C. Simmons M. D.

Sept 20, 1917 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. mos. ds. In the State 77 yrs. 7 mos. ds.

Where was disease contracted, If not at place of death? At the Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept 22, 1917

20-UNDERTAKER: Wm. J. Smith

ADDRESS: 1000 Fayette St

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8623

CERTIFICATE OF DEATH.

41 ✓ D 8623

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Oehm.

(Residence in Baltimore: No. 317 N. Calhoun St.: 53 yrs., 8 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH. Dec 29, 1863 (Month) (Day) (Year)

7-AGE. 53 yrs. 8 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Employer

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Justize Oehm

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. E. Adams.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christina V. M. Oehm

(Address) 312 N. Calhoun St.

15- SEP 20 1917 ROBERT R. KRAUTER

Filed....., 191.... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 19, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 19 1917, that I saw her alive on Sept 19 1917, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Ellis M. D.

Sept 19, 1917 (Address) Univ. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. 2 ds. In the State 58 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 317 N. Calhoun St.

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. Sept. 22, 1917.

20-UNDERTAKER. Mr & Mrs Jno W. Leupel — ADDRESS 801 N Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8621

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8621

1 PLACE OF DEATH

REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 2104 Ramsay St. WARD)

2 FULL NAME Hannah Pielert

(Residence in Baltimore: No. 2104 Ramsay St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 5, 1844 (Month) (Day) (Year)

7 AGE: 73 yrs. 3 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Prussia

PARENTS

10 NAME OF FATHER: Frederick Wm. Lachman

11 BIRTHPLACE OF FATHER (State or country): Prussia

12 MAIDEN NAME OF MOTHER: Elizabeth (Last name unknown)

13 BIRTHPLACE OF MOTHER (State or country): Prussia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Pielert

(Address) 2105 Ramsay St.

15

Filed SEP 20 1917, 191 ROBERT R. KRAUTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 19, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1917, to Sept 19 1917, that I saw h[illegible] alive on Sept 19, 1917, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(Duration) yrs. mos. ds

Contributory (SECONDARY) Senile Exhaustion

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 19, 1917 (Address) 1426 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 21, 1917

20 UNDERTAKER: Sept 13 Co[illegible] — ADDRESS: 1003 Park St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 8625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 W. Lexington ST.; 5 WARD)

REGISTERED No. C 1780 ✓ D 8625

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Gutierrez

(Residence in Baltimore: No. 1201 W Lexington St.; — yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, unknown (Month) (Day) 1843 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Frederick Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Ella Miller

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna R. Marck

(Address) 1201 W Lexington St

15-

Filed SEP 21 1917, 191 HARRY O. ANDERSON Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Sept 18 1917, that I saw her alive on Sept 18 1917, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Ch interstitial Nephritis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. D. Jacobs M. D.

9/19, 191 7 (Address) 1121 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 21, 191 7

20-UNDERTAKER Robert Burkeson — ADDRESS Lathoum Hollins St

D 3626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 3626

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Grele

(Residence in Baltimore: No. Auburn St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	?

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 21 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): Gro

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Grele

(Address) .....

15-

Filed ....., 191.... HARRY O. ANDERSON
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis, years
Duration, 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Sept 20 191.7 (Address) 105 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY	....., 19....
20-UNDERTAKER	ADDRESS

Health Commissioner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8627

CERTIFICATE OF DEATH.

D 8627

81

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Madison ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raphael Wolf

(Residence in Baltimore: No. 2308 Madison ave St.; 36 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 6 (Day), 1881 (Year)

7-AGE, 86 yrs. 4 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Elias Wolf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margret Baum

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Lewis

(Address)..... 1411 E Balto St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20 9/20/17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1917, to Sept 20 1917, that I saw h[illegible] alive on Sept 20 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Multiple sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia lungs (Duration) yrs. mos. 2 ds.

(Signed) J. Frederick Lutz M. D.

Sept 21, 191.7. (Address) 2040 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oheb Sholom Cem	9/22, 191..
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8628

CERTIFICATE OF DEATH.

28 ✓ D 8628

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.; 13 ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(Residence in Baltimore: No. ..... St.; ..... yrs., 3 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1 ..... (Year) 7

7-AGE, ... yrs. 3 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at Service

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... John H. Lewis .....

(Address) ... 610 Brant St. .....

15-

SEP 21 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) ..... (Day) ....., 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191... , to ..... 191... , that I saw h... alive on ..... 191... , and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Sept. 21, 191...

20-UNDERTAKER Georges J. Rauth

ADDRESS 1235 Hayford ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8629 — 37 — D 8629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hahnemann General Hospital. REGISTERED NO. C

CITY OF BALTIMORE: (No. 1122 N. Mount — ST.; 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Premature child of Ida L. Hammen & Philip L. Hammen

(Residence in Baltimore: No. 624 N. Payson St. — yrs. — mos. 10 min. — da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September (Month) 19th (Day), 1917 (Year)

7-AGE, 10 Minutes yrs. mos. da.

If LESS than 1 day, hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Philip L. Hammen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Ida L. Tangmeyer

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida L. Hammen

(Address) 624 N. Payson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 19th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,

that I saw him alive on Sept. 19th, 1917,

and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Maternal Syphilis

(Duration) ....yrs. ....mos. ....da.

(Signed) Maurice E. Shannon M. D.

9/19/..., 191.7 (Address) 3300 W. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 Minutes mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Johns Hopkins Hospital — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Maurice E. Shannon M.D. — ADDRESS

Specimen sent to Johns Hopkins

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8630

CERTIFICATE OF DEATH.

79 D 8630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Curley ST.: 7 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Paul

(Residence in Baltimore: No. 517 N. Curley St.: 26 yrs., 2 mos. 17 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 1st (Month) (Day), 1891 (Year)

7-AGE, 26 yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Ernst Stecker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Paul

(Address) 517 N. Curley

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 11 1917, that I saw h[er] alive on " 18 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

No Post Mortem

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) H. Hollenberg M. D.

Sept 20, 1917. (Address) 1518 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept 21, 191..
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna

SEP 21 1917 HENRY C. ANDREWS BURIAL PERMIT CLERK

Spec.—8-24-14—M. & T.—2000 Bks.

D 8631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 8631

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 Edmondson ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Maria Kuhow

(Residence in Baltimore: No. 2301 Edmondson ave St.; — yrs., — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOW, WIDOWER OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 26, 1835
(Month) (Day) (Year)

7-AGE, 82 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, — Arnldurff

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country) Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George Kuth

(Address) 2301 Edmondson

15-

SEP 21 1917 HARRY O. ANDREWS

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Sept 19 1917, that I saw h— alive on Sept 19 1917, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Sept 21, 191.. (Address) 2231 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Sept 23, 191.7

20-UNDERTAKER Ger. Kuhn & Son — ADDRESS 2503 Edmondson

D 8632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8632

CERTIFICATE OF DEATH.

REGISTERED No. C 186

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1834 n Dulaney St. 8, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Brandau

(Residence in Baltimore: No. 1834 n Dulaney, St.; 9 yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, June (Month) 22 (Day), 1886 (Year)

7-AGE, 31 yrs. 10 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER: Geo Deihl

11-BIRTHPLACE OF FATHER (State or Country): Pa.

12-MAIDEN NAME OF MOTHER: Laura Mann

13-BIRTHPLACE OF MOTHER (State or Country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Brandau

(Address) 1834 n Dulaney

15-

Filed SEP 21 1917, 191... HARRY O. ANDREWS Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) I find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abortion, criminal induced

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Clifford Dunbar M. D. (Coroner.)

Sept 20, 1917, (Address) 1 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL, Sept 22 1917.

20-UNDERTAKER: Zirkeler & Zirkeler — ADDRESS 1739 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

D 8633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8633

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Blankenhahn

(Residence in Baltimore: No. Rosedale Md.

St.: —yrs. —mos. —ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 23, 1880
(Month) (Day) (Year)

7-AGE, 37 yrs. 4 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. August Blankenhahn

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 20, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6 191 7, to Sept. 20 191 7, that I saw h[illegible] alive on September 20 191 7, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Intestinal perforation as a complication of typhoid fever.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Typhoid Fever.

(Duration) yrs. mos. 14 ds.

(Signed) [illegible] M. D.

Sept. 20, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rosedale Md.

19-PLACE OF BURIAL OR REMOVAL. Zion Lutheran Cem. DATE OF BURIAL. Sept. 22nd, 1917.

20-UNDERTAKER Roszell Bond ADDRESS Fullerton Md.

Frank Lassahn & Son

Spec.—8-24-14—M. & T.—2000 Bks.

D 8631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8631

CERTIFICATE OF DEATH.

+ 81

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Good.

(Residence in Baltimore: No. St Joseph Hosp. St.; yrs., 5 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Not known, ... (Month) (Day) (Year)

7-AGE, 81 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp Resd.

(Address)

15-

Filed SEP 21 1917, 191... HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 16 1917, to Sept. 20 1917, that I saw h[im] alive on Sept. 20 1917, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Dont know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) J. Edward Evans M. D.

9/21/17 191... (Address) St. Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 4 ds. In the State yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death? at home.

Former or usual residence Charlotte Hall, Maryland

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Sept 21, 191.7

20-UNDERTAKER E V B Hall — ADDRESS 115 E Mead St

D 8635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8635

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3039 N. North St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Burk

(Residence in Baltimore: No. 3039 N North St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) September (Day) 1860 (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Balt. Md.

PARENTS.

10-NAME OF FATHER, Henry Hornung

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Mary E. Dixon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ena Hornung

(Address) 3039 N North ave

15-

SEP 21 1917 HARRY C. ANDREWS

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Sept (Day) 20 (Year) 1917

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of left Breast

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph Kunz, M. D.

(Coroner)

....., 191.. (Address) 39 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Sept 23 1917
20-UNDERTAKER	ADDRESS
Wm Dickneshons	North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8636

REGISTERED NO. C 1207

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1914 N Pulaski St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Virginia Louisa Jane Belton

(Residence in Baltimore: No. 1914 Pulaski St. St.: 76 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~, ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: June 19, 1841 (Month) (Day) (Year)

7 AGE: 76 yrs. 6 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): do

9 BIRTHPLACE (State or country): Talbot Co Md.

PARENTS

10 NAME OF FATHER: James Neill

11 BIRTHPLACE OF FATHER (State or country): Talbot Co. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Talbot Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelina Belton

(Address) 1914 Pulaski St

15 Filed SEP 21 1917, 191 HARRY O. ANDREWS Registrar of Vital Statistics REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 20, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1917, to Sept 20 1917, that I saw h.. alive on Sept 17, 1917, and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia
Chronic interstitial nephritis (Duration) 5 yrs. 4 mos. ds

Contributory (SECONDARY) Senility (Duration) yrs. mos. 4 ds.

(Signed) Thomas J. Mackey M. D.
Sept 21, 1917 (Address) 527 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Sept 22nd, 1917

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Calhoun & Pollitt Sts

Spec.—8-24-14—M. & T.—2000 Bks.

D 8637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8637

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Franklin Hosp St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Bayline

(Residence in Baltimore: No. 1733 Bel Air Ave St.; Yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male | 4-COLOR OR RACE: white | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1905 (Year)

7-AGE, 11 yrs. 6 mos. 13 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer): Bell Boy

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andrew Bayline

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Anna Dinlauder

13-BIRTHPLACE OF MOTHER (State or Country), Maryland Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Bayline

(Address) 1733 Bel Air

15-

Filed ....., 191.....

Registrar.

SEP 21 1917 HARRY O. ANDREWS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 18 1917, that I saw him alive on Sept 18 1917, and that death occurred, on the date stated above, at 2.05 p.m.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Compound fracture R forearm

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) H. Todd Tennehouse M. D.

Sept 18, 1917 (Address) Franklin Hosp Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. | In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 1733 Balt ave

19-PLACE OF BURIAL OR REMOVAL: Loudon Pk | DATE OF BURIAL, Sept 21, 1917

20-UNDERTAKER: E E Fanning | ADDRESS 1410 Battery Ave

(over)

Spec.—8-24-14—M. & T.—2000 Bks.

D 8633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Elizabeth C. Rasch (Hospital)

(Residence in Baltimore: No. ~~100 St Johns~~ Roland Park St.; ... yrs., mos. 35 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 31 (Month) (Day); 1864 (Year)

7-AGE, 53 yrs. 21 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Nathaniel Chesley

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Sarah Rieman

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O'Keefe Md

(Address) Union Protestant Infirmary

15-

Filed SEP 21 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15th 1917, to Sept 20th 1917, that I saw her alive on Sept 20 1917, and that death occurred, on the date stated above, at 6.34 m.

The CAUSE OF DEATH* was as follows:

Appendicitis Suppurative

Operation Aug 15th 17

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) yrs. mos. ds.

(Signed) G. P. Micklethwaite M. D.

Sept 20 1917. (Address) U. P. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 35 ds. In the State yrs. Life mos. ? ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 100 St Johns Road Roland Park

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER John O. Mitchell — ADDRESS 1201 W. Fayette

SEP 21 1917 — Filed — Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

D 8639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8629

109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Bridgeport Sanitorium St.; 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline B. Worthington

(Residence in Baltimore: No. 709 W Lafayette St. St.; 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 16, (Month) (Day) 1853 (Year)

7-AGE, 64 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard L. Ogle

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Priscilla Bowie

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eulean B. Worthington

(Address) 709 W. Lafayette Ave

15-

SEP 21 1917

HARRY C. ANDREWS
Registrar of Vital Statistics

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 19th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 18 1917, to September 19th 1917, that I saw her alive on September 19th 1917, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
from band of adhesions

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Operation Surgical shock

(Duration) — yrs. — mos. 9 ds.

(Signed) Hubert F. Eichelman M. D.

Sept. 19, 1917. (Address) 122 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 709 W Lafayette Ave

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Sept. 21, 1917.

20-UNDERTAKER John O. Mitchell

ADDRESS 1201 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 31 8610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+104 31 8610

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Preston

(Residence in Baltimore: No. Rossville md St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, November 4, 1906 (Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Preston

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Coupling

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15 1917, to Sept 20 1917, that I saw her alive on September 20 1917, and that death occurred, on the date stated above, at 5 40 p m.

The CAUSE OF DEATH* was as follows:

Pleo-colitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Pyelo-nephritis

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Henry B. Conrad M. D.

Sept. 20, 1917. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rossville Md

19-PLACE OF BURIAL OR REMOVAL, Dowdes Chapel Putty Hill — DATE OF BURIAL, Sept 23, 1917

20-UNDERTAKER Mrs Wm John M. Teufel — ADDRESS 501 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8621 D 8621

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Weinberg.

(Residence in Baltimore: No. 502 S. Bentlow St. St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. April (Month) 3 (Day), 1917 (Year)

7-AGE, 0 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Weinberg.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ida Cohen.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps

(Address) Johns Hopkins Hospital

15-

SEP 21 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 17 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug. 31 1917, to Sept. 17 1917, that I saw her alive on Sept. 17 191, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion, acute.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry R. Conrad M. D.

Sept. 17, 191. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 17 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 502 S. Bentlow St

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

HENRY R. CONRAD JOHNS HOPKINS HOSPITAL SEP 21 1917

Burial Permit Clerk

Commissioner of Health

Spec.—8-24-14—M. & T.—2000 Bks.

D 8642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8642

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 McMechen ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Johnson

(Residence in Baltimore: No. 526 McMechen St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July (Month) 25 (Day), 1842 (Year)

7-AGE, 75 yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Richard Smallwood

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Kathrine Burley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. N. Jones Per .....

(Address) 526 N. McMechen St.

15- SEP 21 1917 ROBERT B. FRAUTER Registrar.

Filed....., 191.....

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1917, to Sept 20 1917, that I saw her alive on Sept 20 1917, and that death occurred, on the date stated above, at 5.10 p.m.

The CAUSE OF DEATH* was as follows:

(a) .....

(b) Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Wright M. D.

Sept 21, 1917 (Address) 1209 Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Sept 22 1917.

20-UNDERTAKER Theodore Hulse — ADDRESS 113 Wolfe St

Martha A. Turner.

D 8643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8643

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1226 Eutaw St., WARD) 16

REGISTERED No. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A Turner

(Residence in Baltimore: No. 1226 Eutaw St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) 6 (Day) 17, (Year) 1837

7-AGE, ... 79 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bright

(Address) 1226 Eutaw

15-

SEP 21 1916

ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Sept (Day) 20, (Year) 1916

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Sept 20, 191 6. (Address) 1226 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, Sept 22 19...

20-UNDERTAKER Robt J Jones | ADDRESS 1424 W Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 8641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8641

1-PLACE OF DEATH Bowers Ct.

CITY OF BALTIMORE: (No. 246 Bowers Ct. St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond H McComas

(Residence in Baltimore: No. 246 Bowers Court St.; ....yrs. ....mos. ....ds.)

Bowers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, Sept 1, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Raymond H. McComas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bessie Brice

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond H McComas

(Address) 246 Bowers Court

15-

SEP 21 1917

Filed....., 191.... ROBERT P. BRAUTER

Registrar.

Burial Permit ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 191 7, to Sept 20 191 7, that I saw h[illegible] alive on Sept 20 191 7, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) D H Lochhead M. D.

9/20, 191.. (Address) 1104 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER Wilbur Brown — ADDRESS 114 N. Schroeder St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 8645

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 E. Fairmount Ave ST.: 6 WARD)

2-FULL NAME Margaret J. Smith

(Residence in Baltimore: No. 1927 E. Fairmount Ave St.: .....yrs.....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug 25 (Month), 1897 (Day), (Year)

7-AGE,	If LESS than 1 day,
20 yrs. — mos. 25 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, J. Wm Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Elizabeth Miller

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Wm Smith

(Address) 1927 Fairmount Ave

15-

Filed....., 191.....

SEP 21 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 19 (Month) (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 18 1917, that I saw h.r. alive on Sept 18 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(Duration) .....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Sept. 22, 1917.
20-UNDERTAKER	**ADDRESS**
Christian Miller	2334 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert Nim

D 8616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 ✓ D 8616

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2 E. Druid St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Nim

(Residence in Baltimore: No. 2 E. Druid St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1 ..... (Day) (Year)

7-AGE. About 35 ...yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

506 886

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Austin Ellis Fisher

(Address) 2nd E Druid

15-

SEP 21 1917 ROBERT B. KRAUTER Burial Permit Clerk

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental electrocution
Res. Administering
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) Chas. Grason Preston M. D.
(Coroner.)
Sept 21, 1917. (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, 9/22 1917

20-UNDERTAKER Jack Lewis

ADDRESS 114 N Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 8647

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1829 N. Register ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa E. Morgan

(Residence in Baltimore: No. 829 N. Register St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July 24, 1858.
(Month) (Day) (Year)

7-AGE, 59 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Peter Morgan

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Filmina Custer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. L. Morgan

(Address) 1829 N. Register St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 191, to Sept 20 1917, that I saw her alive on Sept 20 1917, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(Duration) yrs. mos. 4 ds.

(Signed) John T. Chew M. D.

3/24/18 (Address) 1623 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. North

SEP 21 1917 ROBERT B. KRAUTER REGISTRAR BUREAU OF VITAL STATISTICS

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 D 8648

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hebron Hospital St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Snyder

(Residence in Baltimore: No. 2743 Huntington Ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Married

6-DATE OF BIRTH, July (Month) 15 (Day), 1882 (Year)

7-AGE,	If LESS than 1 day,
32 yrs. 2 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, George Keck

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. md.

12-MAIDEN NAME OF MOTHER Barbara Bell

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Snyder

(Address) 2743 Huntingdon

15-

SEP 21 1914 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 19 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1914, to Sept 19- 1914, that I saw h[er] alive on Sept 19 1914, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

1. Chronic Endocarditis decompensation
Chronic Myocarditis Arteriosclerosis Heart
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation Heart
(Duration) 1 yrs. mos. ds.

(Signed) Wm Coffey M. D.

Sept 19, 1914. (Address) Mt Hebron Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 5 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 2743 Huntington Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	Sept. 23, 1914.

20-UNDERTAKER	ADDRESS
Wm. Coott	502 E. Hall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—5000 Blks.

D 8649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D 8649

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3424 Mondawmin Av. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmina C Bushnell

(Residence in Baltimore: No. 3424 Mondawmin Av St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Married

6-DATE OF BIRTH, June 4 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Shelton Island N.Y.

PARENTS.

10-NAME OF FATHER, Calvin M. Griffin

11-BIRTHPLACE OF FATHER (State or Country) N.Y.

12-MAIDEN NAME OF MOTHER Abbie Condon

13-BIRTHPLACE OF MOTHER (State or Country), N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. E. Bushnell

(Address) 3424 Mondawmin Av

15-

Filed....., 191.....

Registrar.

SEP 21 1917 ROBT. B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14th 1917, to Sept 21 1917, that I saw h[er] alive on Sept 21st 1917, and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Senile Decay

(Duration) ....yrs. ....mos. ....ds.

(Signed) Esther L Goldman M. D.

Sept 21st, 1917 (Address) 2321 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Western Cem	Sept 23 1917
20-UNDERTAKER Wm Cook	ADDRESS 602 E. Madison

D 8650

HEALTH DEPARTMENT—CITY OF BALTIMORE.

150 ✓

D 8650

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 147 W. Hamburg St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaiah Wickham.(C)

(Residence in Baltimore: No. 147 W. Hamburg St. St.; 11 yrs., 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, July 18th. 1917., / (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(h) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Trevilliam Wickham.(C)

11-BIRTHPLACE OF FATHER (State or Country), Richmond Va.

12-MAIDEN NAME OF MOTHER Maggie Boyer.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Wickham.(C) mother.

(Address) 147 W. Hamburg St.

15- SEP 22 1917 HUGH C. ANDREWS

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.
Congenital.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Sept, 21, 1917 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	9-22 1917
20-UNDERTAKER John H. Toadvine	ADDRESS 142 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8651 — 64 — D 8651

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 855 Vine ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Buxton

(Residence in Baltimore: No. 855 Vine St St.; 50 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

24 040

9-BIRTHPLACE, (State or Country), Seaford Del

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas M. Campion

(Address) 856 Vine St

15-

Filed ....., 191.....

Registrar.

SEP 22 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 19 1917, that I saw him alive on Sept 19 1917, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

.....Carcinoma of pylorus.....

.....

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Cirrhosis of Kidneys

..... (Duration) —yrs. —mos. —ds.

(Signed) J. L. Stowe M. D.

Sept 20, 191.. (Address) 6 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 9.22 191.

20-UNDERTAKER John H. Toadvine

ADDRESS 143 W Fred St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8652

CERTIFICATE OF DEATH

28 ✓ D 8652

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 691 Reiree ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agusta Braun

(Residence in Baltimore: No. 691 Reiree St.)

41 yrs. 7 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Femal Col

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Unknown, 1876 (Month) (Day) (Year)

7-AGE: 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 021

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Peter Dent

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Harriet Gray

13-BIRTHPLACE OF MOTHER (State or country): New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nettie Dent

(Address) 691 Reiree St

15.

Filed SEP 22 1917, 191 .....

MARY U. ANDREWS
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 21 st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1917, to Sept 21 st 1917, that I saw h[illegible] alive on Sept 20 th, 1917, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) One yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C Ken Williams M. D.

Sept 21, 1917 (Address) 401 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cheltenham Md

DATE OF BURIAL: Sept 22, 1917

20-UNDERTAKER: Kuhl Eastern

ADDRESS 916 Cathedral

D 8653

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8653

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1021 Ashland Ave St.: 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Daisy Robinson

(Residence in Baltimore: No. 1021 Ashland Ave St.: yrs. mos. 16 dys.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Small

4 COLOR OR RACE: a a

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): single

6 DATE OF BIRTH: Sept 6, 1917 (Month) (Day) (Year)

7 AGE: yrs. mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto city

PARENTS

10 NAME OF FATHER: John Robinson

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Robinson

(Address) 1021 ashland ave

15.

Filed ....., 191 .....

REGISTRAR

SEP 22 1917

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 (Month) 20 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/19, 1917, to 9/20 1917, that I saw h er alive on 9/19, 1917, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), A. L. Hornstein M. D.

9/21, 1917 (Address) 733 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt auburn Cemetery DATE OF BURIAL: Sept 22, 1917

20 UNDERTAKER: H. L. Grook ADDRESS: 1601 McElderry St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.: 14 WARD) REGISTERED No. C 1094

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Parker.

(Residence in Baltimore: No. 1019 N. Fremont St.; — yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Unknown, 1880
(Month) (Day) (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Walters

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances Green

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Parker

(Address) 1017 S. Fremont St.

15-

Filed ....., 191.....

Registrar.

SEP 22 1917

HENRY O. AS ARMS
Burial Permit Clerk

(Over)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1917, to Sept. 20, 1917, that I saw her alive on Sept. 20, 1917, and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

1. Volvulus

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Stomach

(Duration) yrs. mos. ds.

(Signed) Jas Davidson M. D.

Sept 20, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State 37 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1019 N. Fremont St.

19-PLACE OF REMOVAL: Governors Run Calvert Co Md

DATE OF BURIAL, Sept 22 1917.

20-UNDERTAKER A E Groth

ADDRESS 1405 W. Elderry

D 8655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8655

CERTIFICATE OF DEATH.

64

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 10 Wheeler ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Amos

(Residence in Baltimore: No. 10 Wheeler ave St.)

85 yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Sept. (Month) 12 (Day), 1832 (Year)

7-AGE, 85 yrs. — mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer): Produce dealer

65

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sara J. Amos

(Address) 2219 Druid Hill ave

15-

SEP 22 1917 HARRY O. ANDREWS

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) I find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy due to Arterio Sclerosis

(Duration) .....yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) old age

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M Fenlon M. D.
(Coroner.)

Sept 22 191 7 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Sept. 22 1917

20-UNDERTAKER Josiah Sypor

ADDRESS 1610 W North ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 8656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 8656

+48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospt. St.; H WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Catherine Glenn

(Residence in Baltimore: No. John Hopkins Hospital St.; — yrs., 1 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widowed

6-DATE OF BIRTH, Don't know (Month) ....., 1 (Day) ....., (Year)

7-AGE,	If LESS than 1 day,
79 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Glenn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Glenn

(Address) 3121 Clifton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 — 1917, to Sept 21 1917, that I saw her alive on Sept. 21 1917, and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

..... (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

..... (Duration) — yrs. — mos. — ds.

(Signed) Dr J Wm

9/21, 191.7. (Address) Md Gen. Hosp. M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 21 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Germany - Md

19-PLACE OF BURIAL OR REMOVAL, Stone Chapel-Zion Co — DATE OF BURIAL, 9/24, 191.7

20-UNDERTAKER H. E. Cook — ADDRESS 502 E. N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 8657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Milton Gossom

(Residence in Baltimore: No. 608 W. Lafayette & Inf. Church Home St.; yrs., mos. 2 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 18 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
....yrs. mos. 2 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Balt. City

PARENTS.

10-NAME OF FATHER, Edwin Milton Gossom

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Ruby Mae Wallace

13-BIRTHPLACE OF MOTHER (State or Country), Princess Ann Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H.H.Hamman

(Address) Church Home

15-

Filed SEP 22 1917, 191.... HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1917, to Sept 21 1917, that I saw him alive on above dates 1917, and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (?)

Concussion

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H.H.Hamman M. D.

Sept 21, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 2 ds. In the State ....yrs. mos. 2 ds.

Where was disease contracted, if not at place of death? At birth perhaps

Former or usual residence 608 W Lafayette Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Sept 22 1917

20-UNDERTAKER	ADDRESS
A Feeney & Sons	608 Lafayette Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8658 — 120 — D 8658

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 3506 Park Heights Ave St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John E. Wallace

(Residence in Baltimore: No. 3506 Park Heights Ave. 15 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept (Month) 20 (Day), 1862 (Year)

7 AGE: 55 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John D Wallace

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Catharine Meurer

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie J Wallace

(Address) 3506 Park Heights Ave

15

Filed SEP 22 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 20 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1917, to Sept 20 1917, that I saw h alive on Sept 20, 1917, and that death occurred, on the date stated above, at 4-45 PM

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Uremic poisoning

(Duration) yrs. mos. 6 ds.

(Signed) Francis D. McCarney M. D.

Sept 20, 1917 (Address) 416 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Balto-Cem — DATE OF BURIAL: Sep 22, 1917

20 UNDERTAKER: M Gorsuch — ADDRESS: 758 W 31st

Spec.—8-24-14—M. & T.—2000 Bks.

D 8659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

D 8659

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Prot Infirmary ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Gorsch

(Residence in Baltimore: No. 1220 Hull St

St.: ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 9 (Month) (Day), 1914. (Year)

7-AGE, 3 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child. 688
(b) General nature of industry, business, or establishment in which employed (or employer)..... 688

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Gorsch

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Annie Maher

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Kelly MD

(Address) U P D

15-

Filed SEP 22 1917 HARRY C. ANDREWS ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 20 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 20 1917, that I saw him alive on Sept 20 1917, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Kidney

" Liver

Autopsy Diagnosis

..... (Duration) yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

..... (Duration) — yrs. — mos. — ds.

(Signed) G. F. Mischlettwaite M. D.

Sept. 20, 1917. (Address) U. P. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State all life yrs. mos. ds.

Where was disease contracted, if not at place of death? at home.

Former or usual residence 1220 Hull St

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Sept 22 1917

20-UNDERTAKER, Mrs. J. L. Evans Son — ADDRESS, 1428 Charles St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

P 8660

CERTIFICATE OF DEATH.

120 D 8660

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Carrollton Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cordelia Gardiner

(Residence in Baltimore: No. 822 N Carrollton Ave St.; 80 yrs., 10 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. October 30, 1836. (Month) (Day) (Year)

7-AGE, 80 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. F. E. Hall

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER M Eliza Lynch

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Broadfoot

(Address) 1481 John St

15-

Filed ....., 191.....

Registrar.

SEP 22 1917 HARRY O. ANDREWS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 24 1917, to Sept. 20 1917, that I saw her alive on Sept. 20 1917, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arterio Sclerosis & Senility

Abt 5 years (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Prostration

..... (Duration) Abt 6 months yrs. ....mos. ....ds.

(Signed) Carlton McCoy M. D.

Sept 22, 1917. (Address) 1107 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Sept 22, 191.7

20-UNDERTAKER J. P. Boulware Son — ADDRESS North Ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Entry of information should be carefully supplied.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8661

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Elizabeth Swartzer

(Residence in Baltimore: No. 310 N. Stricker St. St.; ..... yrs., ... mos. 2 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, Sept. 20, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George L. Swartzer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Annie E. Langpood

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George L. Swartzer

(Address) 310 N. Stricker St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept. 22 1917, that I saw h[illegible] alive on Sept. 22 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bell D. Murray M. D.

Sept. 22 1917 (Address) 510 N. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem. DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER Robert B. Cook ADDRESS 1031 Park Ave

St.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8662

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1026 N. Calvert ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. Gibbs

(Residence in Baltimore: No. #1026 N. Calvert St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. wh Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widowed

6-DATE OF BIRTH, June (Month) 28 (Day), 1837 (Year)

7-AGE, 80 yrs. 2 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Banker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maine

PARENTS.

10-NAME OF FATHER, Rufus Gibbs

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER Sears

13-BIRTHPLACE OF MOTHER (State or Country), Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Gibbs

(Address) 1026 N. Calvert St

15- Filed SEP 22 1917, 191.... HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 191.7, to Sept 21 191.7, that I saw h[illegible] alive on Sept 21 191.7, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Valve disease

(Original Stenosis Insufficiency)

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) General anemia

Chronic (Duration) 1 yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 22, 191.7. (Address) 1008 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Sept 23rd, 191.7.

20-UNDERTAKER Henry W. Jenkins Sons Co ADDRESS Orchard & McCulloh Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8663

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 E Pratt ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Lee Grove

(Residence in Baltimore: No. 2906 E Pratt St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 4, 1891
(Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer) Printing business

219 063

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas M. Lee Grove

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Virginia Hudson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Virginia Lee Grove

(Address) 2906 E. Pratt St.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-23 1917, to 9-21 1917, that I saw him alive on 9-20 1917, and that death occurred, on the date stated above, at 11.20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J E Gatch M. D.

9-22, 191 7 (Address) 1802 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, Sept. 24, 1917

20-UNDERTAKER Robert T. Barnes — ADDRESS 1412 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8661 D 8661

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Priscilla V. Browning

(Residence in Baltimore: No. 1525 Eutaw Place St.; 50 yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, June 5, 1831
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
86 yrs. 3 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Howard Co. Md

PARENTS.

10-NAME OF FATHER, Nathan Tarbert

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER Elinor Vance

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Kenzel

(Address) 1525 Eutaw Place

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 21st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1917, to Sept 21st 1917, that I saw her alive on September 20 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis (Senile Heart)

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Dilatation of

(Durntion) yrs. mos. 10 ds.

(Signed) W. Rowe M. D.

Sept 22, 1917. (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Sept. 23, 1917.

20-UNDERTAKER Harry W. Ellen ADDRESS 1944 W. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8665 — D 8665

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Hillman ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harace Ringold

(Residence in Baltimore: No. 908 Hillman St.; — yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Fred Ringold

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelin Ringold

(Address) 908 Hillman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1917, to Sept 20 1917, that I saw him alive on Sept 20 1917, and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Lungs 2 yrs

(Duration) yrs. 2 mos. 5 ds.

(Signed) Dr Geo Ringold M. D.

Sept 21, 1917. (Address) 708 Eaton St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Gardens — DATE OF BURIAL, Sept 24 1917

20-UNDERTAKER Charles P. Jones — ADDRESS 235 Pine St

D 8666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X/69 D 8666

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 9 Locust Point. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael J.Korjeff.

(Residence in Baltimore: No. None. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month), (Day), 1 (Year)

7-AGE, 38 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Steward on (b) General nature of industry, business, or establishment in which employed (or employer): Russian Steamer Vologda. 086

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A.Bochecu. 2nd Mate on Steamer Vologda.

(Address) Pier 9 Locust Point.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 21st.1917. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.

Sept.21,1917. (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence....Russia.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Sept. 22 1917
20-UNDERTAKER	ADDRESS
Carruthers	1075 Light

D 8667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8667

Registered No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1530 N Bruce St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Hampton

(Residence in Baltimore: No. 1530 N Bruce St., ~~yrs.~~, ~~mos.~~ ~~ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1865 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Unknown

(Address) 1530 N Bruce

15-

Filed SEP 22 1917, 191.... HARRY O. ANDREWS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy
Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Secondary Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Whitridge Williams M. D.
(Coroner.)
Sept 22, 191.. (Address) 712 E Lan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER Edward Ruggold ADDRESS 1763 N Carey st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8663 D 8663

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. St.: 15 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Vinton Lansdale

(Residence in Baltimore: No. 4107 Main Ave. (Forest Park) St.; 55 yrs., ? mos., ? ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ? ? 1862
(Month) (Day) (Year)

7-AGE, 55 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. National Exch. Bank
(b) General nature of industry, business, or establishment in which employed (or employer). 836

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, R. V. Lansdale

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Eliz A. Tucker

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Daisy V. Lansdale

(Address) 4107 Main Ave.

15-

Filed SEP 22 1917, 191.... Registrar. HARRY O. ANDREWS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 22 1917, that I saw him alive on Sept 22 1917, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Sigmoid with Metastases to the liver

(Duration) Unknown

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept 22, 1917 (Address) Main Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos 10 ds. In the State 55 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4107 Main Ave. (Forest Park)

19-PLACE OF BURIAL OR REMOVAL Green Mount Cy DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER Stewart & Howard Co ADDRESS 108 W. North

Spec.—5-19-13—M. & T.—500 Bks.

D 8669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 D 8669

REGISTERED NO. C

1-PLACE OF DEATH Skin & Cancer Hospital

CITY OF BALTIMORE: (No. 2510 Greenmount Ave ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James F. Goodwin

(Residence in Baltimore: No. 1701 Hope St. St.; 3 yrs.,) mos.) ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 24 (Day), 1879 (Year)

7-AGE, 38 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Motor Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Ob

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, John Goodwin.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Ann Houser

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. Kaufmann

(Address) 1701 Hope St.

15- SEP 22 1917 HARRY C. ANDREWS Special Transit Clerk

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 21st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5th 1917, to Sept 21st 1917, that I saw him alive on Sept 21st 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Testis

Metastasis Brain, temporal Lobe (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo. W. Cross M. D.

Sept 21st 1917 (Address) 1000 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 16 ds. In the State 38 yrs. 0 mos. 00 ds.

Where was disease contracted, if not at place of death? 1701 Hope St.

Former or usual residence 1701 Hope St.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER Henry J. Ford & Son — ADDRESS 1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Wm B Redgrave)

D 8670

HEALTH DEPARTMENT—CITY OF BALTIMORE

154 D 8670

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 621 E 34 St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B Redgrave

(Residence in Baltimore: No. 621 E 34 St.)

St.: yrs. 7 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Feb 23, 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lumber Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hospital

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John B Redgrave

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Hopler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Jay

(Address) 621 E 34 St

15-

Filed SEP 22 1917, 191.....

HARRY O. ANDREWS
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept, 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Wirt Steiner M. D.
(Coroner.)

191... (Address) M. S. Dept

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 23 1917

20-UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8671

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 8671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2201 N. Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Matthews

(Residence in Baltimore: No. 2201 N. Calvert St. St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Sept 26, 1840 (Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Duties

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Amos Matthews

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. Md.

12-MAIDEN NAME OF MOTHER Ellen Marsh

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella L. Matthews

(Address) 2201 N. Calvert St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 21st, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 21 1917, that I saw her alive on Sept 20th 1917, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis —

3 yrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. ds.

(Signed) Robert L. Mitchell M. D.

Sept 21, 1917. (Address) 711 Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept. 24, 1917.

20-UNDERTAKER John O. Mitchell — ADDRESS 120 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17
2
93

D 8672

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

28 D 8672

CITY OF BALTIMORE (No. 525 Walnut St. 17 Ward)

REGISTERED No. C

2-FULL NAME Clarence Thomas

(Residence in Baltimore: No. 525 Walnut

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Single

6-DATE OF BIRTH, March 3, 1893
(Month) (Day) (Year)

7-AGE, 24 yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Corbin Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md. Dec'd

12-MAIDEN NAME OF MOTHER Louisa Hill

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1007 S. 17 St Hill

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Duration
CONTRIBUTORY (Secondary)
(Duration)
Signed
(Coroner) M. D.
(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, Pleasant Rest Cemetery — DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER, Lonron and Mrs R A Elliott — ADDRESS 506 East 1st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 8673

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 313 Elliot pl (ST.: 1 WARD)

2-FULL NAME Henry Drachek (Froelich)

(Residence in Baltimore: No. 313 Elliot pl

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. Like mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Nov (Month) 04 (Day), 1852 (Year)

7-AGE. 34 yrs. 9 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rope Fuller
(b) General nature of industry, business, or establishment in which employed (or employer): 383 Pratt

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Drachek

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Ampfada

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Drachek

(Address) 313 Elliot pl

15-

Filed SEP 22 1917, 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Washington (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Clavicle

(Duration) yrs. mos. ds.

(Signed) Henry Ryan (Coroner.) M. D.

9 yrs, 191 7. (Address) 1610 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Sept 23, 1917

20-UNDERTAKER Zickler & Zickler

ADDRESS 1739 E. Eager

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

B 8671

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 8672

CERTIFICATE OF DEATH.

54

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 N. Gilmor St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fransiska Vonruf

(Residence in Baltimore: No. 600 N Gilmor St.; Yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 18 (Month) (Day), 1840 (Year)

7-AGE, 76 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Saxony

PARENTS.

10-NAME OF FATHER, John Vonruf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henrietta Conrad

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Otto Vonruf

(Address) 600 N. Gilmor

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 51 1917, to Sept 21 1917, that I saw h.. alive on Sept 21, 51 1917, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

about 6 mo (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) John T. Mangan M. D.

....., 191... (Address) 1002 Edmondson ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. | DATE OF BURIAL, Sept 23, 191.

20-UNDERTAKER, H. Dickman & Son | ADDRESS

Dr Mangan 1002 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8675

CERTIFICATE OF DEATH.

94

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Hanover st. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Thoebring

(Residence in Baltimore: No. 1910 Hanover st.

St.: 33 yrs., 5 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Male.	White	Married

6-DATE OF BIRTH, ...Mar.....26....., 1884
(Month) (Day) (Year)

7-AGE, ...33....yrs....5....mos..24..ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer in Dry
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dock 640

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Adolfred Thoebring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Thoebring

(Address) 1910 Hanover

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1917, to Sept 20 1917, that I saw h[illegible] alive on Sept 20, 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Ataxia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 21, 1917. (Address) 1728 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, Sept 23, 1917.

20-UNDERTAKER J. F. & M. Kelly

ADDRESS 1308 E. Fort

N. B.—Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8676

CERTIFICATE OF DEATH.

150 D 8676

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Ridgely St. St.; 21 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Josephine Bulgem.

(Residence in Baltimore: No. 1109 Ridgely St St.; ..... yrs., ... mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. Sept 6th, 1917.
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles F. Bulgem

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Mary J. Deagle

13-BIRTHPLACE OF MOTHER (State or Country). Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Chas. F. Bulgem

(Address) 1109 Ridgely St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 21 1917, that I saw h[illegible] alive on Sept 20 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Mastoiditis + Streptococcus Septicemia

..... (Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. M. Lemmerhirt M. D.

Sept 24, 1917. (Address) 826 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem. DATE OF BURIAL, Sept 22, 191 7

20-UNDERTAKER John J. Keenan Sons ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 316 East St. 5 WARD)

CERTIFICATE OF DEATH.

REGISTERED No. C 84

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Livolsi

(Residence in Baltimore: No. 316 East. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, ... yrs. 8 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Pedro Livolsi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Josephine Romano

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Livolsi

(Address) 316 East.

15-

SEP 22 1917

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Bronchitis Acute

2. .....

3. .....

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Kelly M. D.

(Coroner) 1637 Bank

Sept 22, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, Sept 24 1917

20-UNDERTAKER George J. Ruth

ADDRESS, 733 N Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8678

CERTIFICATE OF DEATH Winn

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 119 N Amity St. (WARD) 18

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie May Winn

(Residence in Baltimore: No. 119 N Amity St.; 21 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mott T. Winn

(Address) 407 N Poppleton St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 20 1917, that I saw h alive on Sept 17 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) H. T. Worthington M. D.

Sept 21, 191.. (Address) 539 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Sept 22, 191..

20-UNDERTAKER Joseph A Burrell

ADDRESS 2317 Druid

Spec.—8-24-14—M. & T.—2000 Bks.

D 8679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8679

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813. S. Ann ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anicla Sobotka

(Residence in Baltimore: No. 813. S. Ann. Str St.; ..... yrs., 7 mos. 16 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	~~Married~~ Single

6-DATE OF BIRTH, Feb. (Month) 6 (Day), 1917 (Year)

7-AGE, ... yrs. 7 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Dupont

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Karol Sobotka

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER Mary Kocon

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Karol Sobotka

(Address) 813. S. Ann St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 191 7, to Sept 22 191 7, that I saw h.. alive on Sept 20 191 7, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Indigestion

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary.	Sept 24 191 7.
20-UNDERTAKER	ADDRESS
William Frankowski	161 S. Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8680

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8680

CERTIFICATE OF DEATH.

28

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 E. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kesseling (Henry Kesseling)

(Residence in Baltimore: No. 1209 E Lexington St.) (If less than 1 day, ...hrs. .....mins. 1 yr., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb 15, 1854. (Month) (Day) (Year)

7-AGE, 63 yrs. 7 mos. 5½ ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Basket maker

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9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Kesseling

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Widener

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fanny Kesseling

(Address) 1209 E. Lexington St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191 7, to Dec 20 191 7, that I saw h alive on Dec 19 191 7, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Stenosis

..... (Duration) .....yrs. .....mos. 20 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

Dec 21, 1917. (Address) 1. S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Dec 23, 1917.
20-UNDERTAKER Wm Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D SGS1 D SGS1

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 N. Bethel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Bray

(Residence in Baltimore: No. 1604 N. Bethel St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, December 26, 1916
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 26 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Joseph Bray

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Helen Hastner

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Van Clef

(Address) 1604 N. Bethel St

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 22 1917, that I saw h living alive on Sept 21 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Colitis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ... yrs. ... mos. 13 ds.

(Signed) Walter G. Thomas M. D.

Sept 22, 191 7. (Address) 1345 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 24, 1917
20-UNDERTAKER Wm Cook	ADDRESS 503 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 79 D 8682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 W. North ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and ward No. 18.)

2-FULL NAME Sophia Scherer

(Residence in Baltimore: No. 1829 W. North ave. St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept. 24, 1843. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
74 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, August Roebling

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm G Heubel

(Address) 1829 W. North ave.

15-

SEP 23 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21st, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1916, to Sept 21 1917, that I saw h[illegible] alive on Sept 21 1917, and that death occurred, on the date stated above, at 10.20a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

Sept. 21, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western. DATE OF BURIAL, Sept 24, 1917.

20-UNDERTAKER [illegible] ADDRESS 502 E North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8683

CERTIFICATE OF DEATH.

D 8683

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 W. Calvert ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Covington

(Residence in Baltimore: No. 3606 W. Calvert

St.: 74 yrs., 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, October (Month) 9th (Day), 1842 (Year)

7-AGE, 74 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Covington

11-BIRTHPLACE OF FATHER (State or Country), Queen Anns Co

12-MAIDEN NAME OF MOTHER Elizabeth Wills

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Wheeler

(Address) 3506 W. Calvert st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May – 1917, to Sept 22 1917, that I saw h[illegible] alive on Sept 21 1917, and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Harvey B Bert M. D.

Sept 22 1917 (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Sept. 24., 1917
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital ST. 17 WARD)
REGISTERED No. C 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Rukert
(Residence in Baltimore: No. 601 N Fremont ave
St.; yrs., 62 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 4 (Day), 1855 (Year)

7-AGE, 62 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer): Emp/ Boyce

9-BIRTHPLACE. (State or Country), Germany

PARENTS.
10-NAME OF FATHER, Christian Rukert
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Wilhelmina Volkmer
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Catherine Rukert
(Address) 601 N Fremont

15-

Filed SEP 23 1917 191 HARRY C. ANDREWS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock following fracturing pubes & internal injuries caused by being struck and run over by automobile (accident)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. L. Friedell M. D.
(Coroner)
Sept 22 1917. (Address) 312 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)
At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death? Surgical Ward
Former or usual residence 601 N Fremont Ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Sept. 23. 1917

20-UNDERTAKER W M Routzon — ADDRESS 230 N Greene

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8685

CERTIFICATE OF DEATH.

REGISTERED No. C 119

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Pine ST. 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emanuel Brown

(Residence in Baltimore: No. 1805 Pine St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, July (Month) 10 (Day) 1910 (Year)

7-AGE, 7 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Moses Brown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Emma Ferguson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brown

(Address) 1805 Pine St

15-

Filed ....., 191.....

SEP 23 1917 HARRY O. ANDERS Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to true death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lack of proper attention (Duration) yrs. mos. ds.

(Signed) James M Kuehn M. D. (Coroner.)

Sept 21, 1917. (Address) 700 E Chase St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 23 1917

20-UNDERTAKER A. Jones — ADDRESS 207 S Stricker St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Woodberry Ave. ST.; 13 WARD)

REGISTERED NO. C 13 131

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Talbott Ruby

(Residence in Baltimore: No. 2138 Woodberry Ave. St.; — yrs., 2 mos. 11 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word): Single

6-DATE OF BIRTH, July (Month) 10 (Day), 1917 (Year)

7-AGE, — yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Talbott H. Ruby

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Edith D. Crawford

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Talbott H. Ruby

(Address) 2138 Woodberry Ave

15-

Filed....., 191.....

Registrar.

SEP 23 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15th 1917, to Sept 21st 1917, that I saw him alive on Sept. 21st 1917, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia

(Duration) ....yrs. 6 weeks mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. A. Lilich M. D.

Sept 21st, 1917 (Address) 1527 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Mary's Hamden

DATE OF BURIAL: Sept 23, 1917

20-UNDERTAKER: Horace Burgee & Son

ADDRESS: 363 Fells Road

Spec.—8-24-14—M. A —2000 Bks.

D 8687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 8687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Israel Dragon

(Residence in Baltimore: No. 102 S. Paca St.; 22 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day), 1863 (Year)

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clothing
(b) General nature of industry, business, or establishment in which employed (or employer). Tailor 050

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15 1917, to Sept. 21 1917, that I saw him alive on Sept. 21 1917, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Hypertension
Chronic Myocarditis
(Duration) Unknown

CONTRIBUTORY (Secondary) Uraemia + Acute Pul. Edema
(Duration) 2 yrs. mos. 5 ds.

(Signed) Israel J. Finkelstein M. D.

Sept. 21, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 6 mos. 6 ds. In the State 22 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 102 S. Paca St.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale — DATE OF BURIAL, Sept. 23, 191 7

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 8683

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Rennert Av ST.: 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Weiss

(Residence in Baltimore: No. 1114 Rennert Av

S. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Weiss

(Address) 811 S Rose St

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 21, 1917 (Address) 810 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, Sept 23, 17

20-UNDERTAKER P Sonder & Sons

ADDRESS 1711 Mad Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

D 8689

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N Port St ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Zelenka

(Residence in Baltimore: No. 722 N Port St St.; ..... yrs., 8 mos. 10 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Jan (Month) 12 (Day), 1917 (Year)

7-AGE, ... yrs. 8 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Zelenka

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary B Calia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Zelenka

(Address) 722 N Port St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 191 7 to Sept 22 191 7

that I saw h[illegible] alive on Sept 22 191 7

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) [illegible] M. D.

Sept 23 1917 (Address) 722 N Port St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 24 ....., 191....
20-UNDERTAKER	**ADDRESS**
Frank Cracken	1966 Bond

Spec.—8-24-14—M. & T.—2000 Bks.

D 8690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8690

CERTIFICATE OF DEATH.

54

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 W Chase ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amy J Lanier (Lanier)

(Residence in Baltimore: No. 27 W Chase St.; 30 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 25 (Day) 1866 (Year)

7-AGE, 51 yrs. 2 mos. 27 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edmund Lanier

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary A Smith

13-BIRTHPLACE OF MOTHER (State or Country), Vermont

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hallan R Smith

(Address) 900 Maryland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 191 7, to Sept 21 191 7, that I saw her alive on Sept 21 191 7, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

(Duration) one yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hallan R Hilbert M. D.

Sept 22, 191 7 (Address) 1008 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL-	DATE OF BURIAL,
Loudon Park Cem	9 24, 1917
20-UNDERTAKER	ADDRESS
Henry W Jenkins Son Co	1612 Gilford Ave

SEP 23 1917 HARRY G. ANDREWS Burial Permit Clerk

D 8691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8691

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Payson & Eagle ST., 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Tyler

(Residence in Baltimore: No. 817 Mulberry St

St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known, (Month) (Day) 1 (Year)

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor 086
(b) General nature of industry, business, or establishment in which employed (or employer): Sail Boat

506

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Taylor

(Address) 817 Mulberry St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy from arterio-Sclerosis

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 5 yrs. mos. ds.

(Signed) James McFaul M. D. (Coroner.)

Sept 23, 1917. (Address) 7 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept 23, 1917.

20-UNDERTAKER Charles B Jones

ADDRESS 2356 Pine St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48

D 8692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 S Ellwood Ave St.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E. Knight.

(Residence in Baltimore: No. 822 S. Ellwood Ave. St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May 2 (Month) (Day), 1850 (Year)

7-AGE, 67 yrs. 4 mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Invalid.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Canada.

PARENTS.

10-NAME OF FATHER, James Dolan

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Ann Donovan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Knight (Daughter)

(Address) 822 S Ellwood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 191 7, to Sept. 20 191 7, that I saw her alive on Sept. 15 191 7, and that death occurred, on the date stated above, at 0.30 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 13 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) M J McAvoy M. D.

Sept 22, 191 7 (Address) 839 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem | DATE OF BURIAL, Sept 24th, 191 7

20-UNDERTAKER Lilly & Geiler | ADDRESS 403 E Monument St

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & L.—2000 Bks.

D 8693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8693

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N. Lexington ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice V. Gambrill

(Residence in Baltimore: No. 833 N. Lexington St.; 55 yrs., 7 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Jan 27th, 1862 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 7 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cash Girl
(b) General nature of industry, business, or establishment in which employed (or employer): H. Rossborough Bro's

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Stessly

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Emilia Hensley

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Rossborough

(Address) 833 N. Lexington St.

15-

Filed....., 191.....

Registrar.

SEP 23 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22nd, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20th 1917, to Sept 22 1917, that I saw her alive on Sept 21st 1917; and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Cardiac Asthma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(Duration) yrs. mos. ds.

(Signed) Irving Miller M. D.

Sept 22, 1917. (Address) 108 E. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER Mrs Mrs Jno W Siegfried — ADDRESS 801 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42

REGISTERED NO. C D 8691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. ●)

2-FULL NAME Jennie Farrell

(Residence in Baltimore: No. 809 Aisquith St (If St.; 29 yrs., 1 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Married

6-DATE OF BIRTH, August 13th, 1888.
(Month) (Day) (Year)

7-AGE, 29 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House (037)
(b) General nature of industry, business, or establishment in which employed (or employer): Work at Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Mason

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Hanly

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Henry Sorrell

(Address) 809 Aisquith St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Sept 21 1917, that I saw her alive on Sept. 21 1917, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(Duration) ....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Edema of lungs, Carcinoma of Uterus with metastasis

(Duration) ....yrs....mos....ds.

(Signed) E. Marino M. D.

Sept. 22, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 13 ds. In the State ....yrs. life mos. ....ds.

Where was disease contracted, if not at place of death? 2

Former or usual residence? 809 Aisquith St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept. 24, 1917.

20-UNDERTAKER John J Cowan Son ADDRESS 907 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8695 ✓ D 8695

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 220 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcus Sigelman

(Residence in Baltimore: No. 220 S. Bond St.; 26 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 73 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

880 500

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Frank Sigelman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Sigelman

(Address) 220 S. Bond St

15-

Filed....., 191.....
Registrar.

SEP 23 1917 HARRY C. ARCHARD Board of Health Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1917, to Sep 23 1917, that I saw him alive on Sept 23 1917, and that death occurred, on the date stated above, at 10 4 m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

Clinical (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 3 yrs. mos. ds.

(Signed) W. D. Baylis M. D.

9/23, 191.7 (Address) 121 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 220 S. Bond St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Belair Rd

DATE OF BURIAL, Sept 24, 191.7

20-UNDERTAKER D. Levinson Bro

ADDRESS 1107 E. Dalo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8696

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 8696

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2920 Brighton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Hamaron

(Residence in Baltimore: No. 2920 Brighton St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, Nov 27 (Month) (Day), 1843 (Year)

7-AGE, 74 yrs. 6 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, L Fallen

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah Palmer

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Martha V Bragg

(Address) 2920 Brighton St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, Sept. (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1917, to Sept 22nd 1917, that I saw her alive on Sept. 21st 1917, and that death occurred, on the date stated above, at 7.20 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis (Probably Tuberculer.)

Chronic Endocarditis

(Duration) 40 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation.

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) A. L. Williamson M. D.

9-23, 1917. (Address) Raphine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lexington Cemetery — DATE OF BURIAL, Sept 24, 191...

20-UNDERTAKER Vertrees & Son — ADDRESS 1125 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8697.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ I V D 8697.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Univ Hospt ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elwood Jackson

(Residence in Baltimore: No. Univ Hospt St.; ....yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, ...Unknown...., 19.0.1.
(Month) (Day) (Year)

7-AGE, 16 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy at
(b) General nature of industry, business, or establishment in which employed (or employer)..... Md. School for Blind

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Henson Jackson.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Jakes

(Address) 606 W Lafayette

15- SEP 24 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 23 1917, that I saw him alive on Sept 23 1917; and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. ds.

(Signed) B. B. Brumbaugh M. D.

Sept. 23. 1917. (Address) Univ Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death , yrs. mos. 4 ds. In the State yrs. Life mos. ds.

Where was disease contracted, if not at place of death? Berry Md.

Former or usual residence Berry Md.

19-PLACE OF BURIAL OR REMOVAL Oak Brook DATE OF BURIAL, Sept 26 1917.

20-UNDERTAKER M. Sokol & Sons ADDRESS 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6 ✓

D 8693

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 E. Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Comick

(Residence in Baltimore: No. 1530 E. Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, Jan. 24, 1916. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
1 yrs. 8 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Comick

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Edna Comick

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Comick

(Address) 1530 E. Madison St.

15-

Filed....., 191.....

ROBERT R. KRAUTER
SEP 21 1917
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1917, to Sept. 22, 1917, that I saw her alive on Sept. 21, 1917, and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis
Gastro Enteritis

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Influenza Bronchitis

Measles ? (Duration) yrs. mos. ds.

(Signed) H. L. Stinson M. D.

Sept 22 1917 (Address) 1520 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary — DATE OF BURIAL, Sept. 24, 1917.

20-UNDERTAKER Mrs R A Elliott — ADDRESS 306 East St

CAUSE OF DEATH in plain terms, so that it may be understood. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8699 — 38 ✓ — D 8699

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH Ind. Genl Hosp.

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Porter

(Residence in Baltimore: No. 1715 Maryland Ave. St.: ....yrs. ....mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ...Mar.... (Month) ....15.... (Day), 1893 (Year)

7-AGE, ...24.... yrs. ....6.... mos. ....6.... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Oscar Knight

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER ? Crowley

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Howland Packard

(Address) 1715 Maryland Ave

15- ROBERT P. KRAUTER

Filed ..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 21 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Sept-6- 1917, to Sept-20 1917, that I saw h[er] alive on Sept-20 1917, and that death occurred, on the date stated above, at 2.25 a.m.

The CAUSE OF DEATH* was as follows:

....Primary Pneumonia, Lobar
....Focus Unknown
.... (Duration) ....yrs. about 10 mos. ....ds.
CONTRIBUTORY (Secondary) Bi-lateral
Staphylococcus (Duration) ....yrs. about 3 mos. ....ds.
(Signed) B. A. Gano M. D.
Sept. 21, 1917 (Address) Ind. Genl Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 15 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 1715 Maryland Ave.

19-PLACE OF BURIAL, OR REMOVAL. Laurel Cemetary — DATE OF BURIAL, Sept. 24, 1917.

20-UNDERTAKER Mrs R A Elliott — ADDRESS 5-0le Easley

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8700

CERTIFICATE OF DEATH.

64

D 8700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Fremont Ave 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael Dallinger

(Residence in Baltimore: No. 814 Fremont Ave St.: 10 yrs., ... mos., ... ds.)

Cause of death to be plainly stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 18 (Day), 1890 (Year)

7-AGE, 27 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Philip Solomon

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fannie Katz

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Solomon

(Address) 130 N. Front St

15-

Filed....., 191.....

Registrar.

SEP 21 1917 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23d (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 23 1917, that I saw h[illegible] alive on Sept 23 1917, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) ... yrs. ... mos. 3 ds.

(Signed) Benjamin Kahn M. D.

Sept 23, 1917 (Address) 252 N. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Workmen Circle Mt Carmel

DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER Jack Lurds

ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8701

CERTIFICATE OF DEATH

120 ✓

D 8701

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Mc Donogh St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Carroll

(Residence in Baltimore: No. 905 Mc Donogh St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Don't know, ... (Month) ..... (Day) 18.... (Year)

7-AGE 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Somerset Co Md

PARENTS.

10-NAME OF FATHER, Geo Jenkins

11-BIRTHPLACE OF FATHER (State or Country) Somerset Co Md

12-MAIDEN NAME OF MOTHER Lizzie Jenkins

13-BIRTHPLACE OF MOTHER (State or Country) Somerset Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Carrol

(Address) 905 Mc Donough St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 1916, to Sept 21 1917, that I saw h[illegible] alive on Sept 21 1917, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) Abt 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral

(Duration) 1 yrs. mos. 2 ds.

(Signed) Alf A Sagl M. D.

9/27/17, 191... (Address) 709 N Edwards

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER Harry A Vodery ADDRESS 1725 Orleans St

Property of the Department of Vital Statistics. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8702

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Randolph Benny.

(Residence in Baltimore: No. 604 N. Madeira St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Sing

6-DATE OF BIRTH, March 9, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. 6 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), md.

PARENTS.

10-NAME OF FATHER, Abraham Benny.

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Georgie Hennis

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps.

(Address) John Hopkins Hosp

15-

SEP 24 1917

ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Sept 23 1917, that I saw him alive on Sept 23 1917, and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Intussusception Ileocolic

Chronic

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Cannon M. D.

Sept. 23, 1917 (Address) John Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 604 N. Madeira St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Auburn Cem	Sept 24, 191.

20-UNDERTAKER Harry A. Vodery ADDRESS 1321 Auburn St

Cause of death to be written in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8703

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 John ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Corrigan

(Residence in Baltimore: No. 1607 John St.; ..... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, ... January ....., 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Harford Co Md

PARENTS.

10-NAME OF FATHER, Mathew Cain

11-BIRTHPLACE OF FATHER (State or Country) Harford Co Md

12-MAIDEN NAME OF MOTHER Sarah F Neagle

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie M Corrigan

(Address) 1607 John St

15- Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 9 1917, to Sept 22 1917, that I saw her alive on Sept 22 1917, and that death occurred, on the date stated above, at 3 6 m.

The CAUSE OF DEATH* was as follows:

.....

Cardiac Asthenia

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John E O'Neill M. D.

9/22/17, 191.. (Address) 2508 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Ignatius Harford Co DATE OF BURIAL, Sept 25 191 7.

20-UNDERTAKER Mallet Fahey & Sons ADDRESS 516 Lafayette Ave

CAUSE OF DEATH to be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8701

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8701

REGISTERED No. C

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Vineyard Lane St.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Milton T. Buell

(Residence in Baltimore: No. 4 Vineyard Lane St.: yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) ..... (Day), 1840 (Year)

7 AGE: 77 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Manager 086
(b) General nature of industry, business, or establishment in which employed (or employer): of Brewery

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: George W Buell

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Edna Saylor

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Buell

(Address) #4 Vineyard Lane

15. ROBERT R. KRAUTER

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 22 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1917, to Sept 21 1917, that I saw h alive on Sept 21, 1917, and that death occurred, on the date stated above, at 2.A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of heart

(Duration) 5 yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), C. J. Chisholm Jr M. D.

Sept 22, 1917 (Address) 632 Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park | DATE OF BURIAL: Sept 24, 1917

20 UNDERTAKER: Martin Faher & Sons | ADDRESS: 106 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8705

CERTIFICATE OF DEATH.

104 D 8703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Camel ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshal Forrester

(Residence in Baltimore: No. 312 Camel St.; ~ yrs. 8 mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Jan 23 (Month) (Day), 1917 (Year)

7-AGE, ~ yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Marshal Forrester Sr

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mabel Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 312 Camel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23rd (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1917, to Sept 23rd 1917, that I saw h im alive on Sept 23rd 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Colitis

(Duration) ~ yrs. ~ mos. 5 ds.

CONTRIBUTORY (Secondary) None Known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Keller M. D.

Sept 24, 1917. (Address) 222 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Sept, 191...

20-UNDERTAKER Samuels & Hemsley

ADDRESS 5 E Biddle

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 24 1917 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8706 D 8706 10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Stanmore

(Residence in Baltimore: No. 210 S. Schroeder St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Autumn, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Leonard Stanmore

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry D. Chamberlayne

(Address) Johns Hopkins Hosp.

15- SEP 21 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 1917, to Sept. 21 1917, that I saw h[illegible] alive on Sept. 21 1917, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Ileo colitis.

..... (Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Marion Tyler M. D.

Sept 21, 191.. (Address) John Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 ds. In the State 0 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 210 S. Schroeder St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 24, 191.7

20-UNDERTAKER Wilbur Brown — ADDRESS 114 N. Schroeder St.

CAUSE OF DEATH in plain terms. If that in any case is not important. See instructions on back of certificate.

D 8707 — 91 V — D 8707

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH — Registered No. C

CITY OF BALTIMORE (No. 18 E. Lexington St.: 4 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Lowe

(Residence in Baltimore: No. 18 E. Lexington St.: 74 yrs. —— mos. —— ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Cant Say —, 1843 (Month) (Day) (Year)

7-AGE: 74 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Eastern Shore Maryland

PARENTS

10-NAME OF FATHER: Cant Say

11-BIRTHPLACE OF FATHER (State or country): Cant say

12-MAIDEN NAME OF MOTHER: Marie Lowe

13-BIRTHPLACE OF MOTHER (State or country): Eastern Shore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nathan R. Foster

(Address) 1 W Biddle St

15-

Filed ——, 191— REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 23rd 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30th 1917 to Sept. 22nd 1917, that I saw her alive on Sept 20th 1917, and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Bronchs - Pneumonia

—— (Duration) —— yrs. —— mos. 25 ds

Contributory (SECONDARY) Old age

—— (Duration) —— yrs. —— mos. —— ds.

(Signed), Nathan R. Foster M. D.

——, 191— (Address) 1 W Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state: (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem | DATE OF BURIAL: Sept 26 1917

20-UNDERTAKER: Felix B Pye | ADDRESS: 1026 Mulberry St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8703

CERTIFICATE OF DEATH.

105 ✓ D 8703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S Potomac ST.; 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Henning

(Residence in Baltimore: No. 815 S. Potomac St. 58 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, March 2, 1830 (Month) (Day) (Year)

7-AGE, 87 yrs. 6 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Schuck

(Address) 815 S Potomac

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 21 1917, that I saw her alive on Sept 20 1917, and that death occurred, on the date stated above, at 1a. m.

The CAUSE OF DEATH* was as follows:

Enteritis acute (a)
+ Senile (b)

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion (c)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 23 1917. (Address) 3018 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Pauls — DATE OF BURIAL, Sept 24 1917

20-UNDERTAKER J E Sanders & Sons — ADDRESS 1110 Eutaw St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8709 — 28 — D 8709

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 O'Donnell ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Earnest

(Residence in Baltimore: No. 2914 O'Donnell St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Sept. 21, 1867. (Month) (Day) (Year)

7-AGE, 50 yrs. — mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 43
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Armanday Earnest

(Address) 2914 O'Donnell

15-

Filed....., 191.... Registrar.

SEP 24 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 191 7, to Sept 22 191 7, that I saw h— alive on Sept 21 191 7, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 23, 191.. (Address) 534 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pt Carmel — DATE OF BURIAL, Sept 26 191..

20-UNDERTAKER H. Sandt Sons — ADDRESS 1710 Flat St

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8710

CERTIFICATE OF DEATH

D 8710

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1636 N. Bentalou ST. 15 WARD)

Registered No. C

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John N. Forrest

(Residence in Baltimore: No. 1636 N. Bentalou St.: 64 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: white

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Underline the word): Married

6-DATE OF BIRTH: Sept 11 (Month) (Day), 1853 (Year)

7-AGE: 64 yrs. ~~mos.~~ 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 130

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Thomas Forrest

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Mary E. Richardson

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily F. Forrest

(Address) 1636 N. Bentalon St.

15. Filed SEP 24 1917, 191 ROBERT R. KRAUTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 23 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1917, to Sept 23, 1917, that I saw him alive on Sept 23, 1917, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

(Anaemia)
Interstitial Nephritis

(Duration) 4 yrs. mos. ds

Contributory (SECONDARY) Senile Failure

(Duration) yrs. mos. 2 ds.

(Signed) Wm. A. Newell M. D.

191 (Address) 2339 N. Monta

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Baltimore

DATE OF BURIAL: Sept 25, 1917

20-UNDERTAKER: W. S. Tillotson

ADDRESS: 1111 Druid Park Dr

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8711 — 64 — D 8711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1354 Woodyear St ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Randall

(Residence in Baltimore: No. 1354 Woodyear St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, July (Month) 20 (Day) 1813 (Year)

7-AGE, 44 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hester Carter

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myrtle Fitzgerald

(Address) 1354 Woodyear St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/19 191 7, to 9/21 191 7, that I saw h[illegible] alive on 9/21 191 7, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Cerebral Hemorrhage

Paralysis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. Mayo Robertson M. D.

9/22, 191 7 (Address) 713 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lincoln — DATE OF BURIAL, Sept 24 1917

20-UNDERTAKER Hanna & Bridges — ADDRESS 1364 Mass

CAUSE OF DEATH in plain terms. So that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.; 11 WARD)

2-FULL NAME [redacted] Monaky

(Residence in Baltimore: No. 415 W Biddle St. St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, [illegible] 1, 1910
(Month) (Day) (Year)

7-AGE. 7 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Monaky

11-BIRTHPLACE OF FATHER (State or Country), Ind.

12-MAIDEN NAME OF MOTHER Maggie Davy

13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Monaky

(Address) 1716 Maryland Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1917.
(Month) (Day) (Year)

17-) I HEREBY CERTIFY, That I attended deceased from July 3 1917, to Sept 21 1917, that I saw h e alive on Sept 21 1917, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Pyaemia

Abscess on Back (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) M J Eagan M. D.

Sept 22, 1917. (Address) St Joseph

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 1½ ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death? Balt Md

Former or usual residence 415 W Biddle

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER George A. Holland — ADDRESS 1631 Broadway

Time

IMPORTANT—This certificate must be filled in plain terms, so that it may be easily understood. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8713

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8713

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Bond. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Marcinko

(Residence in Baltimore: No. 414 S. Bond St.: 1 yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Sept. 22, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Stephen Marcinko

11-BIRTHPLACE OF FATHER (State or Country). Russian Poland

12-MAIDEN NAME OF MOTHER Annie Bogins ki

13-BIRTHPLACE OF MOTHER (State or Country). Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Marcinko

(Address) 414 S. Bond

15-

SEP 21 1917 ROBERT P. BRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 23 1917, that I saw h[illegible] alive on Sept 23 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) W. J. Adams M. D.

Sept 24, 1917 (Address) 1208 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Sept. 24, 1917
20-UNDERTAKER Wm. Lauzenski	ADDRESS 1611 Eastern Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8711

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8711

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 E Biddle ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry J Burlage

(Residence in Baltimore: No. 1214 E Biddle St.; ....yrs., 9 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. 16, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Harry J Burlage

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Barbara M Schroppler

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Harry J Burlage

(Address) 1214 E Biddle

15-

SEP 24 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 25 1917, that I saw him alive on Sept 23 1917, and that death occurred, on the date stated above, at 5:55 p m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular

(Duration) ....yrs. 1 mos. 5 ds.

(Signed) John D Farley M. D.

9/24, 1917 (Address) 1223 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Stoley Redeemer Cemy	Sept 25, 1917
20-UNDERTAKER Henry Horak Sons	ADDRESS 301 E Eager St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8715 ✓3 D 8715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Hosp ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Stallmann

(Residence in Baltimore: No. 2711 Belair Rd St.; 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 6, 1871.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
46 yrs. 1 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Schuster

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Louis Stallmann

(Address) 2711 Belair Road

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 23 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Stone in Rt Kidney
(Obstruction) Removed from Stone

(Duration) 10 yrs. mos. X ds.

CONTRIBUTORY (Secondary) Acute dilatation of stomach

(Duration) yrs. mos. 1 ds.

(Signed) Wm Deeter M. D.

, 191... (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 2711 Belair Rd

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cemy	Sept 26, 191.7

20-UNDERTAKER	ADDRESS
Henry Storck Sons	130 E Eager St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8716 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 ✓ D 8716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Bernard ST.: 12 WARD) REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Eaton

(Residence in Baltimore: No. 2608 Bernards st. St. 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	white	Widower

6-DATE OF BIRTH. June. (Month) 26. (Day), 1857. (Year)

7-AGE.	If LESS than 1 day,
60. yrs. 7 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Motorman 678
(b) General nature of industry, business, or establishment in which employed (or employer): Electric R.R.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Eaton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Agnes. Eaton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John. H. Eaton

(Address) 2608 Bernard st

15-

Filed SEP 24 1917, 191.... ROBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Sept 24 1917, that I saw h[illegible]alive on Sept 21 1917, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculosis

..... (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Fales M. D.

Sept 24, 1917. (Address) 12 E. 25th st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Glenco. Md.	Sept. 26 1917.
20-UNDERTAKER Schnorr Bros.	ADDRESS 3617 Eastern ave

important. See instructions on back of certificate. Properly classified, exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8717. D 8717.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jud. Guess Hospital St.; WARD)

REGISTERED No. C 138

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Viola McClure

(Residence in Baltimore: No. 1132 Riverside Ave St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ..., (Month) (Day) 1 (Year)

7-AGE, 19 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1132 Riverside Ave

15-

Filed....., 191.....

SEP 24 1917 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1917, to Sept. 23 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis due to Pregnancy 4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept. 23, 1917. (Address) Jud. Guess Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mo 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1132 Riverside Ave

19-PLACE OF BURIAL OR REMOVAL. [illegible] DATE OF BURIAL, Sept 25 1917

20-UNDERTAKER [illegible] ADDRESS 1318 Pine St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Stanislaus Wontrola

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8713

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Aliceanna ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Wontrola

(Residence in Baltimore: No. 1923 Aliceanna St.: yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	S-yr

6-DATE OF BIRTH, Sept 23, 1912 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 5 mos. 10 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Wontrola

11-BIRTHPLACE OF FATHER (State or Country), Austria Poland

12-MAIDEN NAME OF MOTHER Mary Pastor

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Wontrola.

(Address) 1923 Aliceanna St.

15-

Filed ....., 191.....

Registrar.

SEP 24 1917 ROBERT R. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14th 1917, to Sept 22 1917, that I saw him alive on Sept 22 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Jaundice

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Hepatitis & Heart Failure

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Thos. D. Shultz M. D.

Sept 23, 1917 (Address) 1921 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Sept ....., 1917.

20-UNDERTAKER M. F. Sadowski ADDRESS, 905 S. Ann St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8713

28

D 8713

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1207 Edmondson ave. St.; 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Ruth Coffin

(Residence in Baltimore: No. 1207 Edmondson ave St.; 25 yrs. — mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Sept (Month) 18th (Day) 1892 (Year)

7 AGE: 25 yrs. mos. 4 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm R Gault

11 BIRTHPLACE OF FATHER (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Amelia A Krall

13 BIRTHPLACE OF MOTHER (State or country): Balto. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hascal R Coffin

(Address) 1207 Edmondson ave

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 22nd (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1917. to. Sept 22nd 1917. that I saw h[illegible] alive on Sept 21st, 1917. and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C. Ken Williams M. D.

Sept 22 191 7 (Address) 401 Carrollton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Sept. 24 191 7.

20 UNDERTAKER: J. Mitchell

ADDRESS: Rail Road

N.B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8720

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

80

D 8720

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 204 N Carrollton ave. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Francis M Smith

(Residence in Baltimore: No. 204 N. Carrollton ave. Str.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Mar 29, 1843 (Month) (Day) (Year)

7 AGE: 74 yrs. 9 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk U.S.P.O
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9 BIRTHPLACE (State or country): Frederick Co. Md.

PARENTS

10 NAME OF FATHER: David M Smith

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Euhn

13 BIRTHPLACE OF MOTHER (State or country): Euhn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E Smith

(Address) 214 N Carrollton ave

15 Filed SEP 24 1917, 19.. ROBERT R. KRAUTER Registrar of Vital Statistics

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 22 th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 th, 1917, to Sept 22 th 1917, that I saw him alive on Sept 22 th, 1917, and that death occurred, on the date stated above, at 12/55 p m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) two yrs. mos. ds

Contributory (SECONDARY) Bronchitis Chronic

(Duration) 5 yrs. mos. ds.

(Signed) V. Kin Williams M. D.

Sept 22, 1917 (Address) 601 Carrollton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept. 25, 1917

20 UNDERTAKER: John O. Mitchell — ADDRESS: 801 W. Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8721

CERTIFICATE OF DEATH.

119 D 8721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 E Preston ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F Benson

(Residence in Baltimore: No. 2507 E Preston St.; life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 16 (Month) (Day), 188X (Year)

7-AGE, 32 yrs. 11 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Marine
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Engineer

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John B Benson

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Elizabeth Frazier

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Shelby Johnson

(Address) 2503 E Preston

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1917, to Sept 21 1917, that I saw h.m alive on Sept 21 1917, and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Gen. Peritonitis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Appendicitis & Cirrhosis Liver

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Miller M. D.

Sept 23, 1917 (Address) 724 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER Robt J Turner

ADDRESS 1444 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8722

CERTIFICATE OF DEATH.

REGISTERED NO. C D 8722

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt. St.; 4 WARD)

2-FULL NAME Andrew Giles.

(Residence in Baltimore: No. Univ. Hospt. St.; yrs., mos. 8 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Unknown.

6-DATE OF BIRTH, ... (Month) Unknown, (Day) 1 (Year)

7-AGE. About 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Unknown. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Unknown.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) W. N. Black

(Address) Ellicott City Md.

15-

Filed ..... 191.....

SEP 21 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 17 1917, that I saw him alive on Sept 17 1917, and that death occurred, on the date stated above, at 2 10 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Disease

(Duration) Unknown

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. B. Brumbaugh M. D.

Sept 17 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State Unknown yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence Unknown Cleveland Ohio.

19-PLACE OF BURIAL OR REMOVAL, Mt Gilboa, Balto Co. DATE OF BURIAL, Sept 24, 1917

20-UNDERTAKER Easton's Sons ADDRESS Ellicott City.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8723

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 513 East St ST. 5 WARD)

2-FULL NAME Edward Kellum

(Residence in Baltimore: No. 513 East St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ..., (Month) (Day) 1 (Year)

7-AGE, 50 ans

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), Louisiana

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E [illegible]

(Address).....

15-

Filed....., 191.....

15180

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible]

Sept 20, 1917 (Coroner.) .....M. D.

(Address) 1657 Division

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SEPARATE [illegible] JOHNS HOPKINS HOSPITAL [illegible] Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8721

CERTIFICATE OF DEATH.

47 D 8721

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 645 W Lombard ST.; 4 WARD) REGISTERED No. C.....

2-FULL NAME Louis C Gunzlitis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 645 W Lombard St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March — 1911
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
6 yrs. 6 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establisbment in which employed (or employer) NONE-

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Gunzlitis

11-BIRTHPLACE OF FATHER (State or Country) Lithuania Russia

12-MAIDEN NAME OF MOTHER Magdalen Anderson

13-BIRTHPLACE OF MOTHER (State or Country) Lithuania Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Gunzlitis

(Address) 645 W. Lombard St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1917, to Sept 22 1917; that I saw him alive on Sept 22 1917, and that death occurred, on the date stated above, at 10 30 m. pm

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ....yrs. ....mos. 22 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) ....yrs. 1 mos. ....ds.

(Signed) J. M. Fassett M. D.

9-22, 1917. (Address) 812 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cem.	Sept. 25 1917.
20-UNDERTAKER	ADDRESS
John Grobliauckas	425 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8725

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 D 8725

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 240 Albemarle ST. 31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emilia Mazelauskas.

(Residence in Baltimore: No. 240 albermarle ST.; ~~yrs.~~ 1 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July (Month) 29 (Day), 1917 (Year)

7 AGE: ~~yrs.~~ 1 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): 40 Albermarle St.

PARENTS

10 NAME OF FATHER: Anton Mazelauskas

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Petrona Randiske

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Antanas Mazelauskas

(Address) 40 albermarle St.

15

Filed SEP 21 1917, 191 ROBERT R. KRAUTER REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 23 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1917, to Sept 23, 1917, that I saw her alive on Sept 22, 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ~~yrs.~~ 1 mos. 23 ds.

Contributory (SECONDARY) Exhaustion

(Duration) ~~yrs.~~ 1 mos. 23 ds.

(Signed) L. H. Ephraim M. D.

Sept. 23, 1917 (Address) 218 S. Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Stanislaws	Sept 24, 1917.
20 UNDERTAKER	**ADDRESS**
John Gebliauskas	425 So Paca St

D 8726

HEALTH DEPARTMENT---CITY OF BALTIMORE

61

D 8726

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 E Lanvale ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter W Erdman

(Residence in Baltimore: No. 1006 E Lanvale St St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	married

6-DATE OF BIRTH: January (Month) 14 (Day), 1865 (Year)

7-AGE: 52 yrs. 8 mos. 6 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Florist
(b) General nature of industry, business, or establishment in which employed (or employer): 145

9-BIRTHPLACE (State or country): Baltimore Co Md

PARENTS

10-NAME OF FATHER: Fredriek Erdman

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Grace Rud

13-BIRTHPLACE OF MOTHER (State or country): Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alice Erdman

(Address) 1006 E. Lanvale

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20, 1917, to, Sept 22 1917, that I saw h[im] alive on Sept 22 1917, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinomitis

(Duration) ..... yrs ..... mos. 3 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. 3 ds.

(Signed) Hyman Muttbach M. D.

Sept 22, 1917 [Address] 1617 Gorsuch ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park Cem.

DATE OF BURIAL: Sept 24th 1917

20-UNDERTAKER: Geo. J. Kurth

ADDRESS: 1735 Harford

SEP 21 1917 ROBERT R. KRAUTER

Burial Permit

Over

U. S. [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8727

CERTIFICATE OF DEATH.

29 D 8727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 W. Fayette ST. 20 WARD) REGISTERED NO. C

2-FULL NAME Patrick Walsh

(Residence in Baltimore: No. 1816 W. Fayette St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1829 (Year)

7-AGE, 88 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Walsh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Walsh

(Address) 1816 W. Fayette St

15-

Filed ..... 191.....

ROBERT R. KRAUTER
BURIAL Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 24 1917, that I saw h[illegible] alive on Sept 24 1917, and that death occurred, on the date stated above, at 12.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insuf. of Heart

(Duration) Unknown yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 24, 1917. (Address) 108 N Bond Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, I. O. Peters — DATE OF BURIAL, Sept 26, 1917

20-UNDERTAKER Martin Saley & Sons — ADDRESS 606 W Fayette St

Cause of death must be given in plain terms; indefinite or local terms cannot be used. Name of disease may be preceded by the terms acute, chronic, contributory, complicating, etc., as may be proper in each case. Occupation is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8729

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1448 Carroll St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Le Roy Johnigen

(Residence in Baltimore: No. 1448 Carroll St.; ..... yrs., 8 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 11, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER William F. Johnigen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Florence V. Brody

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. F. Johnigen

(Address) 1448 Carroll St.

15-

Filed ..... 191.....

SEP 21 1917 HARRY B. ANDREWS BURIAL PERMIT Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1917, to Sept. 23 1917, that I saw h— alive on Sept 23 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Stephen A. Allen M. D.

Sept 24 1917 (Address) 1448 Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem.

DATE OF BURIAL, Sept 26, 1917

20-UNDERTAKER John Heaman Son

ADDRESS 701 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8729

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2334 Eutaw Place ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Madden

(Residence in Baltimore: No. 2334 Eutaw Place St.; 41 yrs., 0 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, September 17, 1876
(Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 0 mos. 5 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): 042

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas F. Madden

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Anna Cahill

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ella M. Madden

(Address) 2334 Eutaw Place

15-

SEP 23 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1917, to Sept 22 1917, that I saw h[illegible] alive on Sept 22 1917, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bowel with metastases in Brain (Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Exhaustion & family

(Duration) 0 yrs. 1 mos. 0 ds.

(Signed) [illegible] M. D.

Sept 24 (?), 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	9/25, 191..
20-UNDERTAKER [illegible]	ADDRESS [illegible]

STATE of DEATH in plain words, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8730.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8730.

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protest Infirmary WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Geo. F. Harrison (Florence M)

(Residence in Baltimore: No. Walbert Apts St.; Life yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) widowed

6-DATE OF BIRTH, April (Month) 10 (Day), 1873 (Year)

7-AGE, 44 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, R. Mordecai

11-BIRTHPLACE OF FATHER (State or Country), Charleston S.C.

12-MAIDEN NAME OF MOTHER Emma Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. R. Mordecai

(Address) Stevenson Md

15-

SEP 24 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from August 1 1917, to Sept 23 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 11:10 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Typhoid meningitis

(Duration) yrs. mos. 3 ds.

(Signed) G. R. Micklethwaite M. D.

Sept. 23 1917. (Address) U.P.H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 5 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? In Virginia

Former or usual residence Walbert Apts.

19-PLACE OF BURIAL OR REMOVAL, St. Thomas Lem Garrison — DATE OF BURIAL, Sept 25, 1917.

20-UNDERTAKER Henry W. Jenkins Sons — ADDRESS Orchard & McCulloh

Cause of death must be plainly written. Any physician who refuses or neglects to sign certificate is liable to a penalty of $50.00. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8731 — 104 — D 8731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1605 N Mulberry St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecilia Maria Thompson

(Residence in Baltimore: No. 1605 N Mulberry St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 3 (Day) 1916 (Year)

7-AGE, ...yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Cordia Thompson

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Jennie Tully

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Brooks & Son

(Address) 17 S Eutaw St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 23 1917, that I saw h- alive on Sept 23 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ....yrs. ....mos. 6 ds.

(Signed) E. V. Cockburn M. D.

Sept 24, 1917. (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER Robt Brooks & Son — ADDRESS 17 S Eutaw St

CAUSE OF DEATH in plain terms, as that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 Ward) REGISTERED NO. C

2-FULL NAME Nelson Rosenstock

(Residence in Baltimore: No. In Hospital St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 16 (Day), 1885 (Year)

7-AGE, 32 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Leon Rosenstock

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Julia Schloss

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 24 (Day), 1917 (Year).

17-I HEREBY CERTIFY, That I attended deceased from Sept 20 1917. to Sept 24 1917. that I saw h alive on September 24 1917. and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Astrocytoma Cerebri)

Edema.

Duration 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Failure

Duration yrs. mos. ds.

(Signed) K. P. Batchelor M. D.

Sept. 24 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5237 Reisterstown Road.

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew — DATE OF BURIAL, Sept. 25, 191.7.

20-UNDERTAKER J. Ahrens & Co — ADDRESS 411 Madison

Cases of death in penal institutions, and that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8732

CERTIFICATE OF DEATH.

64 D 8732

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 820 Burgundy n ST.; 22 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Hartenstine

(Residence in Baltimore: No. 820 Burgundy n St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 17 (Day), 1857 (Year)

7-AGE, 60 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 820

9-BIRTHPLACE, (State or Country), Washington D. C

PARENTS.

10-NAME OF FATHER, John Ryan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Charles H. Hartenstine

(Address).....820 Burgundy n.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 24 1917, that I saw her alive on Sept 21 1917, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

1 Apoplexy

(Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

Sept. 24 191.7. (Address)..... Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Washington D. C — DATE OF BURIAL, Sept. 26 1917.

20-UNDERTAKER Jas Sanders Son — ADDRESS 2173 Pa

CAUSE OF DEATH must be plainly stated, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

D 8731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8734

CERTIFICATE OF DEATH.

REGISTERED No. C 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 9 Locust Point. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Johnson.(C)

(Residence in Baltimore: No. 2411 N.Stockton St. St.: 2 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know ....., 1 ..... (Month) (Day) (Year)

7-AGE, 29 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 504 074

9-BIRTHPLACE, (State or Country), A.A.Co.Md.

PARENTS.

10-NAME OF FATHER, Henry Johnson.(C)

11-BIRTHPLACE OF FATHER (State or Country), A.A.Co.Md.

12-MAIDEN NAME OF MOTHER Louise Harrison.(C)

13-BIRTHPLACE OF MOTHER (State or Country), A.A.Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert A.Mason.(C)

(Address) 1548 Leslie St.

15-

Filed ....., 191.....

Registrar.

SEP 24 1917 HARRY C. ANDREWS Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 22nd. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Geo. M. Leasmann M. D. (Coroner.)

Sept. 23, 1917 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mellville Co. DATE OF BURIAL, Sept 25 1917

20-UNDERTAKER Edw. Ruggold. Md ADDRESS 1463 N. Carey

Spec.—8-24-14—M. & T.—2000 Bks.

D 8735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 8735

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3809 Clifton ave ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie D. Markley

(Residence in Baltimore: No. 3809 Clifton ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH: March 11, 1870
(Month) (Day) (Year)

7-AGE, 47 yrs. 6 mos. 13 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Wm H. Trickey

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Margaret Boyer

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H A Markley

(Address) 3809 Clifton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24 1917, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 24 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

..... (Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Endo. carditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Prentiss M. D.

Sept. 24, 1917. (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Media, Delaware Co. Pa. DATE OF BURIAL, Sept. 26 191..

20-UNDERTAKER Wm Trickey & Son ADDRESS Church & Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8736

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hospers) (St.: Hull & Woodbery) (WARD) 29 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Shaffer

(Residence in Baltimore: No. 2927 Cedar Ave. St. 37 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 14 (Day), 1838 (Year)

7-AGE, 79 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer)..... 075

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Phillip Shaffer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Miller

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Shaffer

(Address) 2927 Cedar Ave.

15-

Filed....., 191.....

Registrar.

REP 21 1917 HARRY C. ANDREWS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) J. Fred Morrison M. D.
(Coroner.)

Sept 24 191 7 (Address) 3632 Boundary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 27, 1917.

20-UNDERTAKER Horace Burgee & Son

ADDRESS 360 Falls Road

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8737 D 8737

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Heiser

(Residence in Baltimore: No. Univ Hospt St.; yrs., mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Unknown, 1883.
(Month) (Day) (Year)

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): (37)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Kluetsch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ada (Unknown)

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Heiser

(Address) Eastern Av Near North Pt Road

15-

Filed SEP 21 1917, 191.... Registrar HARRY D. ARTHUR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1917, to Sept 23 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 1 45 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Fever

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Hem...

orrhage (Duration) yrs. mos. ds.

(Signed) B. A. Brown M. D.

Sept 23, 1917 (Address) Univ Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 30 ds. In the State yrs. Life mos. ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence Eastern Ave Road. Colgate P.O. Md.

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery DATE OF BURIAL, Sept. 25, 1917.

20-UNDERTAKER Christian Miller ADDRESS 2334 Jefferson St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8738

CERTIFICATE OF DEATH.

35

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 419 S. Dallas ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Gerstbrech

(Residence in Baltimore: No. 419 S. Dallas St.; 33 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, Aug. 9th, 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Martin Bryzukowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Gerstbrech

(Address) 419 S. Dallas St.

15-

Filed 4 SEP 21 1917, 191...

ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1917, to Sept. 21 1917, that I saw h[illegible] alive on Sept 21 1917, and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Complications of illness

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept. 21, 1917 (Address) Charles [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	Sept. 25, 1917.
20-UNDERTAKER	ADDRESS
Randell Giffel Son	330 S. Bond

CAUSE OF DEATH must be properly certified, exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8739

CERTIFICATE OF DEATH.

D 8739

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 10 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Squire

(Residence in Baltimore: No. Little Sisters of the Poor St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED~~ (Write the word.) Wid.

6-DATE OF BIRTH, ... (Month) December (Day) 1 (Year) .....

7-AGE, 79 ..... yrs. 79 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Brand

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anny Woods

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 , that I saw her alive on Sept 23 191 7, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Sclerosis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) F. H. Warner M. D.

Sept 24, 191 7 (Address) 1133 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 8 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Sept. 27, 1917

20-UNDERTAKER George L. Roth

ADDRESS 1735 Harford Ave.

SEP 25 1917

Registrar of Vital Statistics.

Every Physician, Undertaker, Executor, Administrator or Householder having knowledge of any death is required by law to report the same to the Registrar of Vital Statistics, 1211 E. Baltimore St., Baltimore, Md., within 24 hours after death occurs. See instructions on back of certificate.

Peter Rutola

D 8710 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8710

CERTIFICATE OF DEATH.

REGISTERED No. C 175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. WARD)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Peter Rutola

(Residence in Baltimore: No. 211 S. 7th St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	White	Single

6-DATE OF BIRTH. July 25 (Month) (Day) 1913 (Year)

7-AGE. 4 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Baby
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Peter Rutola,

11-BIRTHPLACE OF FATHER (State or Country). Italy.

12-MAIDEN NAME OF MOTHER. Susan Melo

13-BIRTHPLACE OF MOTHER (State or Country). Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Petrie Rutola

(Address) 7th St

15-

Filed SEP 25 1917, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 24, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Traumatism

.....from run by Auto car

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed).....(Coroner.) M. D.

Sept 25 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....Highlandtown

Former or usual residence.....Highlandtown Mass.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Patrick Cemetery	Sept 25, 1917
20-UNDERTAKER. George J. Ruth	ADDRESS 1735 Hanford ave.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8711

CERTIFICATE OF DEATH.

28v 8711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Brent St.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard E. Whiting

(Residence in Baltimore: No. 1907 Brent St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 25 (Day), 1892 (Year)

7-AGE, 15 yrs. 7 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward E Whiting

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ida May Boyer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida M Whiting

(Address) 1907 Brent St

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1911 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 2 1911, to Sept 23 1911, that I saw h.. alive on Sept 23 1911 and that death occurred, on the date stated above, at 1050 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

9/24, 1911. (Address) 1111 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept 25, 1911

20-UNDERTAKER Samuel Stanley

ADDRESS 1810 Bolton

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8742

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Boone ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Johnson

(Residence in Baltimore: No. 2646 Boone St.; ....yrs.,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug 2, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nelson Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Josephine Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Nelson Johnson

(Address) 2646 Boone St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1917, to Sept 24 1917, that I saw h.. alive on Sept 24 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Congenital debility

(Duration) ....yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. Garnet Thompkins M. D.

Sept 24, 1917. (Address) 1534 W. Fay. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Sept 25, 191.

20-UNDERTAKER Samuel Hensley ADDRESS 3784 Belair

important. See instructions on back of certificate.

D 8713 64 ✓ D 8713

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3123 N. Calvert St. ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Russell Day

(Residence in Baltimore: No. 3123 N. Calvert St. St.: 47 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb. 2, 1862 (Month) (Day) (Year)

7 AGE: 55 years yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION 034
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Grocer

9 BIRTHPLACE (State or country): New London, Frederick County, Md.

PARENTS

10 NAME OF FATHER: Madison L. Day

11 BIRTHPLACE OF FATHER (State or country): Frederick County, Md.

12 MAIDEN NAME OF MOTHER: Fannie E. Miles

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mattie E. Day

(Address) 3123 N. Calvert St.

15 Filed SEP 25 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 22, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1917, to Sept 22 1917, that I saw him alive on Sept 22, 1917, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H. London M. D.

Sept 25, 1917. (Address) 700 N North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetary — DATE OF BURIAL: Sept. 25 1917

20 UNDERTAKER: Joseph B Cook — ADDRESS: 1003 W. Balto.

D 8741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 8741

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1937 Christian ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 8.)

2-FULL NAME Johanne Hain

(Residence in Baltimore: No. 1937 Christian St.; 1 yrs., 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word) Sing

6-DATE OF BIRTH, May (Month) 17 (Day), 1916 (Year)

7-AGE, 1 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Elwood Hain

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emma Overlow

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elwood Hain

(Address) 1937 Christian St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Got Blood on mouth Ruptured Lobe of Brain accidental fall in yard

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Local Meningitis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) James McTavish M. D. (Coroner.)

Sept 22, 191 (Address) 704 Cloud

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet DATE OF BURIAL, Sept 25 19 17

20-UNDERTAKER Joseph B Cook ADDRESS 1003 N Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8745 — 91 — D 8715

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Kuyser ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick F. Stradmeyer

(Residence in Baltimore: No. 1620 Kuyser st St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Oct. (Month) 6 (Day), 1869 (Year)

7-AGE: 47 yrs. 11 mos. 18 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: Rudolph Stradmeyer

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Schmidt

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Resch

(Address) 1104 S. Second st

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23, 1917, to, Sept 24 1917, that I saw h... alive on Sept 23 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Double

(Duration) ..... yrs. mos. 3 ds.

Contributory (SECONDARY) Pneumonia

(Duration) ..... yrs. mos. 3 ds.

(Signed) C B Carman M. D.

Sept 24 191 7. [Address] 1301 N Caroline

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Schwartze — DATE OF BURIAL: Sept. 26, 191 7

20-UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 E. Eager

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8716

CERTIFICATE OF DEATH.

REGISTERED No. C 161

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Wallace

(Residence in Baltimore: No. 1304 Bruce St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Boy

6-DATE OF BIRTH, ... Aug 14, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER Alfred Wallace

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Parker

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Parker

(Address) 1304 Bruce St.

15-

Filed SEP 25 1917, 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, Scalded by hot water on back

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Sept 18, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 5 yrs. mos. ds.

Where was disease contracted, if not at place of death? Hospital

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, SEP 25 1917, 19....

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76 D 8747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Taylor

(Residence in Baltimore: No. 1001 Price Street St.; .....yrs. .....mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. July 8, (Month) (Day) 1886 (Year)

7-AGE, 29 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Annie May

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records Mercy Hosp.

(Address) Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1917, to Sept 22 1917, that I saw h.. alive on Sept 22 1917, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Suppurative Otitis Media

.....

..... (Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Septic Meningitis

..... (Duration).....yrs. 5 mos.....ds.

(Signed) Edward A. Smith M. D.

Sept 22, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 4 ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? 1001 Price St.

Former or usual residence 1001 Price St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, SEP 25 1917, 191...

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

important. See instructions on back of certificate.

SEP 25 1917 ROBERT R. KRAUTER BURIAL PERMIT

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8718

CERTIFICATE OF DEATH.

28 ✓ D 8718

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Forman ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Louise Thompson

(Residence in Baltimore: No. 1816 Forman St

St.; ? yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 1 (Month) (Day) (Year)

7-AGE, 13 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Thompson

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Louise Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Presstman St

15-

Filed SEP 25 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 23 1917, that I saw h[er] alive on Sept 22 1917, and that death occurred, on the date atated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

1. Pulmonary Tuberculosis
Under Treatment Four 22 Days

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Stewart M. D.

Sept 24, 1917. (Address) 1303 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 24, 1917.

20-UNDERTAKER James H Dennis — ADDRESS 1303 Presstman

important. See instructions on back of certificate.

D 8749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8749

REGISTERED No. C 186

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 927 Lemmon St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Titus Barrett

(Residence in Baltimore: No. 927 Lemmon St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1872 (Year)

7-AGE, 45 yrs. 3 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Thomas Barrett

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Spanberg

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barrett

(Address) 927 Lemmon St

15-

Filed SEP 25 1917, 191.... ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Internal injuries, caused by a Coal Registrar falling on his stomach, when he fell while carrying it (Accidental) (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs....mos....ds.

(Signed) Albert L. Driscoll M. D. (Coroner.)

Sept 23, 1917. (Address) 3127 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Sept 26, 1917.

20-UNDERTAKER	ADDRESS
John Steele	1200 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8750

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Braddish Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Enoch Combs

(Residence in Baltimore: No. 1818 Braddish Ave St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Jan (Month) 30 (Day), 1853 (Year)

7-AGE. 64 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9-BIRTHPLACE, (State or Country) St Marys Co Md

PARENTS.

10-NAME OF FATHER, Louis Francis Combs

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co Md

12-MAIDEN NAME OF MOTHER Mariah Abell

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M L Norris

(Address) 1818 Braddish Ave

15- SEP 25 1917

Filed....., 191.... ROBERT B. KRAUTER BUREAU OF VITAL STATISTICS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1917, to Sept 24 1917, that I saw him alive on Sept 24 1917, and that death occurred, on the date stated above, at 10 40 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Chronic Cystitis
Cardiac Asthma

(Duration) 10 or more yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) Dr. Cottage M. D.

....., 191... (Address) 1 S Bulteas Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Middletown Md	Sept 25, 1917
20-UNDERTAKER J M Cook	ADDRESS 502 E North Ave

important. See instructions on back of certificate.

D 8751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 227 ½ Eastern St. 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Ross,

(Residence in Baltimore: No. 227 ½ Eastern, St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) — (Day), 1 (Year)

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tutor
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Joseph Ross

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Hester Bond

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walt Ross

(Address) 227½ Eastern

15-

SEP 25 1917 ROBERT B. KRAPF

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Sept 27, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md. DATE OF BURIAL, Sep 26, 25 1917

20-UNDERTAKER Milton. Davis ADDRESS 413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 llks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8752

CERTIFICATE OF DEATH.

151 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 680 W. Mulberry ST.; 17 WARD) REGISTERED NO. C

2-FULL NAME Infant Thomas

(Residence in Baltimore: No. 680 W. Mulberry St.; 0 yrs., 0 mos. 13 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, September 10, 1917.
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Daniel Thomas

11-BIRTHPLACE OF FATHER (State or Country), Calvert County Md.

12-MAIDEN NAME OF MOTHER Alice Barthene

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emanuel Thomas

(Address) 680 W Mulberry St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 19, 1917, to September 23 1917, that I saw h[illegible] alive on September 23 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) 0 yrs. 0 mos. 13 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Hemmeter, M. D.

Sept 24, 1917. (Address) Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Lanes	Sept 27, 191...
20-UNDERTAKER Charles B Jones	ADDRESS 235 Pine

Cause of death to be plainly entered in ink, preferably typewritten. Every question must be answered if possible. Unknown or doubtful statements are worse than useless. Be particular to fill out items 8, 9, 10, 11, 12, 13, 18, which are important. See instructions on back of certificate.

D 8753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 8753

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 633 Pierce St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Williams

(Residence in Baltimore: No. 633 Pierce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Huckster
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, David Williams

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Williams

(Address) 633 Pierce St

15-

Filed ....., 191.....
Registrar.

ROBERT E. KRAUTZ
SEP 25 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Albert L. Driscoll M. D.
(Coroner)

Sept 23, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER Charles B Jones

ADDRESS 235 N Pine St

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8751

CERTIFICATE OF DEATH.

D 8751

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N Central ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Irvin Parker

(Residence in Baltimore: No. 520 N. Central St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Dec 30, 1916 (Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H. Parker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary A Truman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Truman

(Address) 520 N. Central

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Sept 24 1917, that I saw h[im] alive on Sept 23 1917, and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W C Burns M. D.

Sept 24 191.7 (Address) 520 N Central Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 26 191.7

20-UNDERTAKER Charles B. Jones ADDRESS 2355 E Pine St

important. See instructions on back of certificate.

SEP 25 1917 ROBERT B. KRAETER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8755

CERTIFICATE OF DEATH.

40

REGISTERED No. C.....

D 8755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J Stubbard

(Residence in Baltimore: No. 1530 E Biddle St.; 5/12 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug 30, 185[illegible]
(Month) (Day) (Year)

7-AGE, 62 yrs. 11 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Kenny Madden

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane Rubin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C J Stubbard

(Address) 1530 E Biddle

15-

Filed ....., 191.....

BORE [illegible]

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1917, to Sept 23 1917, that I saw h[illegible] alive on Sept 22 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Duration 6 months
Diagnosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Thomas Curry M. D.

Sept 25, 1917. (Address) 917 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, Sept 27, 1917

20-UNDERTAKER Robt Bonner

ADDRESS 1424 Pine

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8756

CERTIFICATE OF DEATH.

104

D 8756

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Dillon St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Chas Fredel

(Residence in Baltimore: No. 2712 Dillon St St.; Life yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Jan (Month) 19 (Day), 1917 (Year)

7-AGE, ... yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Fredrick Fredel

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Hoon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrick Fredel

(Address) 2712 Dillon St

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 23 1917, that I saw him alive on Sept 23 1917, and that death occurred, on the date stated above, at 7p m.

The CAUSE OF DEATH* was as follows:

Uric Colitis

(Duration) ....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) H. H. Schwatka M. D.

Sept 25, 1917. (Address) 734 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem — DATE OF BURIAL, Sept 25, 1917

20-UNDERTAKER Stephen J Faltkowski — ADDRESS 1019 S Kenwood ave

ROBERT R. CRAUTER

SEP 25 1917

BURIAL PERMIT

Spec.—8-24-14—M. & T.—2000 Bks.

D 8757.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8757.

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 E. Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Packery

(Residence in Baltimore: No. 812 E. Lombard St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. (Month) 29th (Day), 1916. (Year)

7-AGE	If LESS than 1 day,
1 yrs. — mos. 24 ds.	...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Frank Packery

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Lilly LaBlassio

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Packery

(Address) 812 E. Lombard St.

15-

Filed....., 191.....

Registrar.

SEP 25 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 191..., to Sept 23 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. 1 ds.

(Signed) Thos. L. Donaldson M. D.

Sept. 25, 1917. (Address) 1038 W. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent — DATE OF BURIAL, Sept. 26, 1917

20-UNDERTAKER Wendell Lippel & Son — ADDRESS 330 S. Bond St.

important. See instructions on back of certificate.

D 8753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8753

CERTIFICATE OF DEATH.

168

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 3 WARD)

2 FULL NAME Jacob Ehrnie

(Residence in Baltimore: No. Came from 4 S Front St.: yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)

7-AGE, 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) 086

506

9-BIRTHPLACE, (State or Country), Roumania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address)

15-

SEP 25 1917 HARRY O ANDREWS

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas asphyxiation

Probably accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Riley M. D.
(Coroner.)

Sept 21 191.7 (Address) 639 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 4 S Front St

Former or usual residence 4 S Front St

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Sept 22, 1917

20-UNDERTAKER Ed Fanning — ADDRESS 1938 E Lafayette

WR

Spec.—8-24-14—M. & T.—2000 Bks.

D 8759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8759

CERTIFICATE OF DEATH.

REGISTERED No. C 1120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. Fort ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Mary F. Campbell

(Residence in Baltimore: No. 413 E Fort ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	married

6-DATE OF BIRTH, Dec. 1, 1843
(Month) (Day) (Year)

7-AGE, 73 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country) Carolina Co Md

PARENTS.

10-NAME OF FATHER, Thomas Carroll

11-BIRTHPLACE OF FATHER (State or Country), Caroline Co Md

12-MAIDEN NAME OF MOTHER E. Oldham

13-BIRTHPLACE OF MOTHER (State or Country), Caroline Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F Campbell

(Address) 413 E Fort ave

15- SEP 25 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1916, to Sept. 23 1917, that I saw her alive on Sept. 23 1917, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Probably

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) right sided Hemiplegia about 6

(Duration) yrs. mos. ds.

(Signed) Maurice Long M. D.

Sept 24, 1917 (Address) 423 E. Fort

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Sept 26, 1917
20-UNDERTAKER	ADDRESS
C. L. Fleming & Co	Cutter 443

Cause of death in plain terms. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Eva Rothermel)

D 8760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8760

CERTIFICATE OF DEATH.

X184

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 25 1917

Filed., 191.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Steelton Pa.

DATE OF BURIAL, Sept. 26th 1917

20-UNDERTAKER Lilly & Geiler

ADDRESS 403 S. Wolfe St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8761

CERTIFICATE OF DEATH.

151

REGISTERED No. C

D 8761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N. Chapel ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Elizabeth Bongourd

(Residence in Baltimore: No. 20 N. Chapel St.: ....yrs.... 8 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... January (Month) 3 (Day), 1917 (Year)

7-AGE, ...yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John N. Bongourd

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth Schweiger

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. E. Dannenmann

(Address) 141 N. Chapel St

15-

Filed ....., 191.... SEP 25 1917 HARRY C. ANDREWS ..... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 24 1917, that I saw her alive on Sept 24 1917, and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

.....

..... Hydrocephalus

.....

..... (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Cause Unknown

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Isaac M. Chaikin M. D.

Sept 24, 1917. (Address) 1802 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cem. DATE OF BURIAL. Sept 26, 1917

20-UNDERTAKER H. Sander Sons ADDRESS 716 Mad St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8762 D 8762

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Eastern av ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoni majka

(Residence in Baltimore: No. 2022 Eastern av St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 26, 1852
(Month) (Day) (Year)

7-AGE, 61 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 049
(b) General nature of industry, business, or establishment in which employed (or employer)..... oyster shucker

9-BIRTHPLACE, (State or Country), Poland Austria

PARENTS.

10-NAME OF FATHER, Simon majka

11-BIRTHPLACE OF FATHER (State or Country), Poland Austria

12-MAIDEN NAME OF MOTHER Tekla

13-BIRTHPLACE OF MOTHER (State or Country), Poland Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonina majka

(Address) 2022 Eastern av

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 23 1917, that I saw him alive on Sept Tembr 23 1917, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma Dropsy

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. Samuels M.D.

Sept 24, 1917. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL, Sept 26 191 7

20-UNDERTAKER William Frackenreth

ADDRESS 1618 Eastern Ave

Cor

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8763 D 8763

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Eastern av ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Ryderewski

(Residence in Baltimore: No. 1601 Eastern av St.; 1 yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, August 20, 1916.
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wladyslaus Ryderewski

11-BIRTHPLACE OF FATHER (State or Country), Poland Russia

12-MAIDEN NAME OF MOTHER Wladyslawa Hepner

13-BIRTHPLACE OF MOTHER (State or Country), Poland Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladyslaus Ryderewski

(Address) 1601 Eastern av

15- Filed SEP 25 1917, 191.....
HARRY O. ANDREWS
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 24 1917, to September 24 1917, that I saw h in alive on September 24 1917, and that death occurred, on the date stated above, at 3 10 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Intestinal Toxemia

(Duration) ....yrs. 2 mos. ....ds.

(Signed) L. J. Tumulty M. D.

Sept. 25, 1917. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Sept 26, 1917
20-UNDERTAKER	ADDRESS.
W. H. Faulkner's	16 N Eaton Ave.

Important. See instructions on back of certificate.

D 8761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8761

CERTIFICATE OF DEATH.

REGISTERED No. C 1698

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Johns Hopkin Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby [illegible] (Novak

(Residence in Baltimore: No. 1824 Aliceanna St. St.; yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Baby

6-DATE OF BIRTH, Sep. (Month) 14, (Day) 1917 (Year)

7-AGE, ...yrs. ....mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Novak

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Viola Biers

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Viola Biers
(Address) 1824 Aliceanna

15-
Filed SEP 25 1917, 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows: Suffocation, accidental
Mouth rolled on
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY ....
(Secondary)
.... (Duration) ....yrs. ....mos. ....ds.
(Signed) .... (Coroner.) M. D.
Sept. 25, 1917 (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. 11 ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? ....
Former or usual residence ....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary. DATE OF BURIAL, Sept. 26, 1917

20-UNDERTAKER Wm. Fradkowski ADDRESS 1615 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8765 D 8765

CERTIFICATE OF DEATH.

REGISTERED No. C 1270

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 1355 Ward ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Riley

(Residence in Baltimore: No. 1355 Ward St St. 82 yrs., 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk.

5-~~SINGLE, MARRIED, WIDOWED, or DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Oct. 20, 1844 (Month) (Day) (Year)

7-AGE, 82 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer,
(b) General nature of Industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Stewart

(Address) 625 Archer St

15-

Filed....., 191.....

Registrar.

SEP 25 1917

HARRY C. ANDREWS
Registrar Vital Statistics Division

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June, 1917, to Sept 24, 1917, that I saw h[illegible] alive on Sept 17, 1917, and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Oedema Lungs

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John T. Schwartz M. D.

Sept 25, 1917 (Address) 1720 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Sept. 26, 1917

20-UNDERTAKER John H. Tozdin — ADDRESS 1424 W. Hill St

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8766 D 8766

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Elizabeth Blossom

(Residence in Baltimore: No. 725 Bradley St St.; yrs.. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, August (Month) 23 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Ernest Blossom

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Virgie Bunny

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Virgie Bunny.....

(Address).....725 Bradley St.....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to September 1917, that I saw her alive on September 24 1917, and that death occurred, on the date stated above, at 3. P.M.

The CAUSE OF DEATH* was as follows:

..... Premature infant 6½ mos

..... (Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs....mos....ds.

(Signed).....Ruth E. Lapman.....M. D.

Sept 24 1917 (Address) 2733 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Lawn — DATE OF BURIAL, Sept 26, 1917

20-UNDERTAKER Charles B. Jones — ADDRESS 235 Pine St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8767

D 8767

CERTIFICATE OF DEATH.

REGISTERED No. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2144 Woodberry Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milford C Frock

(Residence in Baltimore: No. 2144 Woodberry Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Jan 9 (Month) (Day), 1915 (Year)

7-AGE, 2 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Geo W. Frock

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Cealia A. Williams

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Frock

(Address) 2144 Woodberry Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 25 1917, that I saw h[illegible] alive on Sept 24 1917, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows: Laryngeal Diphtheria

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. C. Dodenhoff M. D.

Sept 26 1917 (Address) 3843 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL Sept 27, 1917

20-UNDERTAKER A S Marshall ADDRESS 3537 Falls Rd

10 A. M.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8768 — 104 — D 8768

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2718 Elliott St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaw Muskikowski

(Residence in Baltimore: No. 2718 Elliott St St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug 15, 1916 (Month) (Day) (Year)

7-AGE, yrs. 1 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Mike Muskikowski

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Leonara Kiszka

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Wlady~~ Mike Muskikowski

(Address) 2718 Elliott St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 23 191 7, to Sept 24 191 7, that I saw h[illegible] alive on Sept 24 191 7 and that death occurred, on the date stated above, at 9p m.

The CAUSE OF DEATH* was as follows:

Cerebro Collaps

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebro Vidital

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

Sept 24, 191 7 (Address) 708 Reed

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Stanislaus Bur	Sept 26, 191 7
20-UNDERTAKER Stephen Stalkowski	ADDRESS 1017 S Linwood

important. See instructions on back of certificate.

Property Examined. Date Statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8769 D 8769

CERTIFICATE OF DEATH.

120 ✓

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 N. Luzerne ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marmaduke Richard Goodman

(Residence in Baltimore: No. 1340 N Luzerne St.; 74 yrs., 7 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb. (Month) 12 (Day), 1843 (Year)

7-AGE, 74 yrs. 7 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 0.75

480

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edward C. Goodman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER — Grizzell

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) daughter Mrs Lillie M. Emory

(Address) 1340 Luzerne

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Sept 25 1917, that I saw h im alive on Sept 24 1917, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

and Unknown (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Uraemic Toxaemia

(Duration)....yrs....mos....ds.

(Signed) B. Peters M.D. M. D.

Sept 25, 1917 (Address) 1305 N Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Sept 27 1917.

20-UNDERTAKER Robt J. Turner — ADDRESS 1492 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 8770

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

115 D 8770

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Willie Wallace Reid

(Residence in Baltimore: No. 2101 Bolton St.: ..... yrs.. 9 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH. July (Month) 7 (Day), 1864 (Year)

7-AGE. 53 yrs. 2 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER. Richard G Banks

11-BIRTHPLACE OF FATHER (State or Country) Rappahannock Va.

12-MAIDEN NAME OF MOTHER Julia Galusha Howlett

13-BIRTHPLACE OF MOTHER (State or Country), Shaftsbury Vermont

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. C. Reid Husband

(Address) 2101 Bolton St

15-

Filed ....., 191.....

SEP 26 1917 ROBERT R. KRAUTER Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 24 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1917, to Sept 24 1917, that I saw her alive on Sept 24 1917, and that death occurred, on the date stated above, at 9 P, m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Exhaustion-Pramyx

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Harlin M. Clark M. D.

Sept 25, 1917. (Address) Womans Hosp. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. ..... ds. In the State 50 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2101 Bolton St

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL. Sept 27, 1917.

20-UNDERTAKER Robt. T Turner

ADDRESS 1442 N Broadway

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8771

CERTIFICATE OF DEATH.

91

D 8771

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1105 Briscoe St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilian Anderson.(C)

(Residence in Baltimore: No. 1105 Briscoe St. St.: 1 yrs., 6 mos. 19 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, March 5th. 1916. (Month) (Day) (Year)

7-AGE, 1 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Anderson.(C)

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Lilian Eggerson.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Martina Brown (C) Aunt. (Informant)
1105 Briscoe St. (Address)

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. M. Kemland M. D. (Coroner.)

Sept, 25, 1917 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Sept. 28., 1917

20-UNDERTAKER Sam. W. Chase-son — ADDRESS 1400. Mosher

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8772

CERTIFICATE OF DEATH.

64 ✓ D 8772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 158 Colvin St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Jenkins

(Residence in Baltimore: No. 158 Colvin St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black A.A.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...September...., 1 ....
(Month) (Day) (Year)

7-AGE, 48 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lab 240

9-BIRTHPLACE, (State or Country), D.C.

PARENTS.

10-NAME OF FATHER, Filip Jenkins

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER Mamie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Jones

(Address) 235 N. Pine St.

15-

Filed ....., 191.... Registrar.

SEP 26 1917 ROBERT L. CAUTE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Sept. 24...., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 21 1917. to Sept. 24 1917, that I saw h[illegible]live on Sept. 24 1917, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

..... (Duration) ....yrs. 1 mos. ....ds.

(Signed) Jud E. Johnson M. D.

9/25, 191.7 (Address) 1526 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept. 26 191...

20-UNDERTAKER Charles B. Jones

ADDRESS 235 Pine

CAUSE OF DEATH must be stated plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 8773

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Upton Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Dorsey

(Residence in Baltimore: No. 1319 Upton Ave St.: ..yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 870

8 97

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, — Smith

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Milton Dorsey .....

(Address) 1319 Upton Ave

15- SEP 26 1917 ROBERT R. KRAUTER Burial Permit Clerk

Filed ....., 191 .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1917, to Sept. 24 1917, that I saw h.. alive on Sept. 23 1917, and that death occurred, on the date stated above, at 3, 6, m.

The CAUSE OF DEATH* was as follows:

..... Carcinoma Primary on Breast & Metastasis of the Heart & Arm Pit .....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... Asthma .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... Alex. Balfour ..... M. D.

Sept. 25 1917. (Address) 700 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ... ...

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 26, 1917

20-UNDERTAKER Samuel Handley — ADDRESS 5 E. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8774

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

28 ✓ 3214

REGISTERED NO. C.

CITY OF BALTIMORE (No. 106 W. York St. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Parker.(C)

(Residence in Baltimore: No. 106 W. York St. St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male.	Colored	Married.

6-DATE OF BIRTH, Do not know. (Month) , / (Day) (Year)

7-AGE. 33. yrs. – mos. – ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer): 074

9-BIRTHPLACE. (State or Country), Little Rock Ark.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr Otto M. Reinhardt. Coroner.
(Address)

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24th. 1917. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.

Sept. 26, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn ✝ DATE OF BURIAL, Sept 28, 1917.

20-UNDERTAKER C. W. Brown & Son ADDRESS 1611 Mt. Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8775
1 PLACE OF DEATH

CERTIFICATE OF DEATH.

1917 D 8775
REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Stanec

(Residence in Baltimore: No. 2334 Fleet. St.; yrs. 37 mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, ... 53 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Day

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frank Stanec.

(Address) 2334 Fleet St.

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Hemorrhage
Caused by Was falling on
(Duration) ... yrs. ... mos. ... ds.
or Robert Dierking Home
CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. 4 ds.

(Signed) M. Riley (Coroner.) ... M. D.
Sept 26, 1917. (Address) 1639 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. will hold Inquest Sept 26-830

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Sept 27, 1917.

20-UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8776

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8776

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 738 Waesche St.: W. Ward) REGISTERED No. C 51

2-FULL NAME Infant of Mary Burley

(Residence in Baltimore: No. 738 Waesche St.: yrs. mos. 1 ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept. (Month) 24, (Day) 1917 (Year)

7-AGE: yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): U.S.

PARENTS

10-NAME OF FATHER: Richard Burley

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Mary Butler

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Burley

(Address) 738 Waesche

15-

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 25, (Day) 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 25, 191 , to. 191 .

that I saw h alive on .191 .

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. ds

Contributory (SECONDARY): 7 months Pregnancy

(Duration) yrs. mos. ds.

(Signed): Henry A. Weinberg M. D.

Sept 26. 191 7 (Address) 724 W. Lafayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Peters

DATE OF BURIAL: Sept 26. 191

20-UNDERTAKER: Charles B Jones

ADDRESS: 231 Pine

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8777

CERTIFICATE OF DEATH.

104 D 8777

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 S. Ellwood ave ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clare O'Connor

(Residence in Baltimore: No. 841 S. Ellwood ave St.; ..... yrs., 5 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 22nd, 1911.
(Month) (Day) (Year)

7-AGE, ... yrs. 6 mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Thomas F. O'Connor

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Lana O'Connor

13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas O'Connor

(Address) 841 S. Ellwood ave.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1917, to Sept 24 1917, that I saw her alive on Sept 24 1917, and that death occurred, on the date stated above, at 4.P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. McAvoy M. D.

Sept. 25, 191.7 (Address) 823 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorbathedral Cem. DATE OF BURIAL, Sept 26, 1917.

20-UNDERTAKER John J. Moran ADDRESS 3[illegible] E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8778

CERTIFICATE OF DEATH.

10 4 D 8778

(REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleonora Rutkowsky

(Residence in Baltimore: No. 312 S. Ann St.; yrs., 6 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Jan. 13, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Joseph Rutkowsky

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Elizabeth Gajeski

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Rutkowsky

(Address) 312 S. Ann St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 24 1917, that I saw h[er] alive on Sept 24 191., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Chronic Nephritis

Duration ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Heart failure

Duration ..... yrs. ..... mos. 1 ds.

(Signed) Thos. H. Shutler M. D.

Sept 24 1917 (Address) 1621 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Sept. 26 1917.

20-UNDERTAKER John A. Inman ADDRESS 300 E. Baltimore St.

ROBERT B. KRAUTH
Registrar

SEP 26 1917

Burial Permit

CAUSE OF DEATH should be plainly written, and should state if any of the diseases mentioned were the result of violence. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8773

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. St.; Altwater 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Altwater

(Residence in Baltimore: No. St. Mary's Co Md St.: yrs.. 5 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, about. ..55.. yrs. ..\.. mos. ..\.. ds.) If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..Manager of..
(b) General nature of industry, business, or establishment in which employed (or employer) ..Farm.. 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Lamence Altwater

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Jacob Altwater

(Address) Edmondson Md.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..September.. (Month) ..24.. (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 4th 1917, to Sept 24 1917, that I saw h.. alive on Sept 24 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

..Strangulation..

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer of Cervix

..... (Duration) ? yrs. ? mos. ? ds.

(Signed) Ernest G. M. Ruge M. D.

Sept 25 1917. (Address) 1 E Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. 19 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. Sept 26, 1917.

20-UNDERTAKER Henry Hauck Son

ADDRESS 130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8780

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 8780

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1103 W. Baltimore ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Mulcahy.

(Residence in Baltimore: No. 1103 W. Baltimore St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, Sept (Month) 25 (Day), 1913 (Year)

7-AGE, 3 yrs. 11 mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm J. Mulcahy.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Marie Edna Huester

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Edna [redacted]

(Address) 1103 W. Baltimore St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1917, to Sept 24 1917, that I saw her alive on Sept 24 1917, and that death occurred, on the date stated above, at 7.8. m.

The CAUSE OF DEATH* was as follows:

meningitis due to influenza bacillus

(Duration) no yrs. no mos. 2 ds.

CONTRIBUTORY (Secondary) gastro-intestinal influenza

(Duration) no yrs. no mos. 28 ds.

(Signed) Chester Roland, M. D.

9-24-, 1917. (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Sept 27, 1917.

20-UNDERTAKER John A. Moore ADDRESS Baltimore Md.

CAUSE OF DEATH must be plainly stated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 8781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S Charles ST.; 27 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Lizzie

(Residence in Baltimore: No. 523 S. Charles St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	White	Married

6-DATE OF BIRTH. Oct 23, (Month) (Day) 1840 (Year)

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home Work
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John F. Jacobs

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Annie Wilder

13-BIRTHPLACE OF MOTHER (State or Country). Port Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Jacobs

(Address) 1735 Wharton St

15-

Filed SEP 26 1917, 191.... REGISTRAR R. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 23, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Sept 23 1917, that I saw h alive on Sept 23 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. 2 mos. 23 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) R. E. Campbell M. D.

Sept 23 191 (Address) 764 W. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	Sept 26, 191....
20-UNDERTAKER Wm. A. Saunders	ADDRESS 1918 Eutaw

CAUSE OF DEATH in plain terms. It may be very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8782

CERTIFICATE OF DEATH.

170 D 8782

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Druid Hill Ave St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella F. Curtis

(Residence in Baltimore: No. 1936 Druid Hill Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1866 (Year)

7-AGE, 51 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home D37

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Richard Goode

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alverta Goode Craig

(Address) 1936 Druid Hill Ave

15-

Filed SEP 26 1917, 191.... ROBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Sept 24 1917, that I saw h Sr alive on Sept 23 1917, and that death occurred, on the date stated above, at 2 25 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. McCard M. D.

9-24, 1917 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel entry — DATE OF BURIAL, sept 26 1917

20-UNDERTAKER J & H Holland — ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2071 31 St ST.; 9 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Warner

(Residence in Baltimore: No. 2071 E 31 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 16 (Day), 1875 (Year)

7-AGE, 43 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Emmelman

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Mary Pfaff

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert E. Warner

(Address) 2071 E. 31 St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1917, to Sept 24 1917, that I saw her alive on Sept 23 1917, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. 18 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 8 ds.

(Signed) Adolph E. Hirschberg M. D.

Sept 25 1917. (Address) 2203 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Sept 27 1917.

20-UNDERTAKER J Berry & Co

ADDRESS 2008 Orleans

Property unclaimed. Exact treatment of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8784

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 N. Mount St. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Howard Walker

(Residence in Baltimore: No. 1044 N Mount St St.; yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July 8- (Month) (Day), 1917 (Year)

7-AGE, yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Bartlett F Walker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah M Christ

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B F Walker

(Address) 1044 N Mount St

15-

SEP 26 1917 ROBERT H. KRAUTER DEPUTY REGISTRAR

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 25th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25th 191 7, to Sept 25th 191 7, that I saw h[illegible] alive on Sept 25th 191 7, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 14 mos. ds.

(Signed) German F Kevan M. D.

Sept 26, 191 7 (Address) 833 N Eutaw as

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery; DATE OF BURIAL, Sept 27 yrs., 191...

20-UNDERTAKER Pattrom & Co; ADDRESS [illegible]

CAUSE OF DEATH to be properly examined. Date statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8785

1 PLACE OF DEATH

CERTIFICATE OF DEATH

D 8785

REGISTERED No. C 40

CITY OF BALTIMORE (No. 1915 Cecil Ave. ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Boflitz

(Residence in Baltimore: No. 1915 Cecil Av. St. 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Nov (Month) 4 (Day), 1857 (Year)

7 AGE: 59 yrs. 10 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: James Williams

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Basley.

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Boflitz

(Address) 1415 Cecil av

15.

Filed SEP 26 1917, 191 ..... ROBERT E. KRAUTZ

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 25 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1917, to Sept. 25, 1917, that I saw h[illegible] alive on Sept. 15, 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chr Brights.

Pneumonia

(Duration) 1 mos. 6 ds

Contributory (SECONDARY) heart failure

(Duration) [illegible] ds.

(Signed) Arthur Heglar M. D.

Sept 26, 1917 (Address) 1024 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green mt [illegible] | DATE OF BURIAL: Sept 27 1917

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8786

CERTIFICATE OF DEATH.

151 D 8786

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Elizabeth Wilhelm

(Residence in Baltimore: No. 1930 N. Patterson Park Ave St.; 1 yr. life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 6, 1917 (Month) (Day) (Year)

7-AGE, yrs. 5 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 880

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas Wilhelm

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Carrie Gleitner

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Wilhelm

(Address) 1930 N. Patterson Park Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1917, to Sept. 25, 1917, that I saw her alive on Sept 25, 1917, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) & acidosis

(Duration) yrs. mos. 2 ds.

(Signed) J. Edward Young M. D.

Sept. 25, 1917. (Address) St Joseph's Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11 ds. In the State life yrs. 5 mos. ds.

Where was disease contracted, if not at place of death? at deceased home

Former or usual residence 1930 N. Patterson P/K. Ave.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept. 27, 1917.

20-UNDERTAKER Frederick G. Fink — ADDRESS 915 N. Gay St.

SEP 26 1917

Please write in plain terms, so that it may be important. See instructions on back of certificate. Cause of death in plain terms, so that it may be of property classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 8787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8787

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie L. Stabler

(Residence in Baltimore: No. 108 E- 29th St. St.; life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... June 4 (Month) (Day), 1895 (Year)

7-AGE, 22 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Co.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Francis Stabler

11-BIRTHPLACE OF FATHER (State or Country), Staunton Va

12-MAIDEN NAME OF MOTHER Martha Peters

13-BIRTHPLACE OF MOTHER (State or Country), Petersburg Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johnson R. Stabler

(Address) 108 E. 29th St.

15- SEP 26 1917

Filed....., 191.... HARRY D. ABRAMS Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 3 1917, to Sept 24 1917, that I saw h[illegible] alive on Sept 24 1917, and that death occurred, on the date stated above, at 11:50 m.

The CAUSE OF DEATH* was as follows:

Pyothorax

(Duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

9/27, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 108 E. 29th St.

Former or usual residence 108 E. 29th St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 27, 1917

20-UNDERTAKER John D. Mitchell — ADDRESS 1200 W. Fayette St.

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D 8788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 331 N Gilmor ST.: 19 WARD) REGISTERED No. C 151

2-FULL NAME Andrew Coyne

(Residence in Baltimore: No. 331 N Gilmor St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug (Month) 21 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or ....mdn.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Earl Coyne

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Julia Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Julia Coyne

(Address) 331 N Gilmor

15-

Filed ....., 191.... Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Congenital debility

was T. Mos. Exhaustion (Duration) ....yrs. 1 mos. ....ds.

(Signed) James McFeeters (Coroner.) M. D.

Sept 25 1917. (Address) 1 W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, Sept 27 1917

20-UNDERTAKER Hilbert Brown — ADDRESS 114 N Schroeder St

D 8789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8789

REGISTERED No. C

1-PLACE OF DEATH Hahnemann General

CITY OF BALTIMORE (No. Md. State Hospital 13 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Bray

(Residence in Baltimore: No. 2253 Florence St)

St.; yrs., 30 mos. ~~ds.~~)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Nov 17, 1880
(Month) (Day) (Year)

7-AGE, 37 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) 0 43 0 40

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas Bray

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Butler

(Address) 2253 Florence St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries & fracture of pelvis bones accidentally by falling from car run over by an Automobile. (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. 2 mos. 1 ds.

(Signed) H. Edward Smith M. D.
(Coroner)

9/26, 191 7 (Address) 910 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 3 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Ellicott City Md

Former or usual residence 2253 Florence St.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	Sept 27 1917
20-UNDERTAKER Holbert Brown	ADDRESS 114 N. Schroeder St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8790

CERTIFICATE OF DEATH

92 D 8790

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Lucy Holliday~~ 538 W. Mulberry St ST. 17 WARD)

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Holliday

(Residence in Baltimore: No. 538 W. Mulberry St St.: 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: ..... (Month) ..... (Day) , 1872 (Year)

7 AGE: 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Abbie Trustee

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Mut Kent

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nelson Trustee

(Address) 518 N Hoffman St

15

Filed ..... , 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 27th (Month) (Day) , 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1917, to Sept 27th 1917, that I saw h-d alive on Sept 24th, 1917, and that death occurred, on the date stated above, at 4 A.M. The CAUSE OF DEATH* was as follows:

Abs. Tuberculosis

(Duration) ..... yrs. ..... mos. 1/2 ds

Contributory (SECONDARY) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Sept 28th, 191 7 (Address) 2 East Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Sept 26 ,191 7

20 UNDERTAKER: John A. Bush

ADDRESS: 1 Division Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8791

CERTIFICATE OF DEATH.

151 D 8791

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Powell

(Residence in Baltimore: No. 1130 22½ St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Negro	X

6-DATE OF BIRTH, Sept 25, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 17 hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work....X....
(b) General nature of industry, business, or establishment in which employed (or employer)....666....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albert Powell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Celeste Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celeste Powell

(Address) 1130 22½ St City

15-

Filed ....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Sept 25 1917, that I saw him alive on Sept 25 1917, and that death occurred, on the date stated above, at 11 50 m.

The CAUSE OF DEATH* was as follows:

Premature birth

(1 hr.)

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Edward P. Smith M. D.

9/28, 191.7. (Address) 2226 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

SEP 28 1917

T5184

Cases of DEATH in plain type, to which it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8792

CERTIFICATE OF DEATH.

64 ✓ D 8792

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 751 Robert St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel J. Stone

(Residence in Baltimore: No. 751 Robert St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, Feb (Month) 1st (Day) 18..2 (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 7 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Sam J. Stone

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Brown

(Address) 751 Robert St.

15-

Filed ..... 7 ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 25 1917, that I saw h— alive on Sept 24 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Apoplexy Cerebral Hemo

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ....yrs. ....mos. 5 ds.

(Signed) ..... M. D.

Sept 25 1917 (Address) 712 S. Stricker

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn St	Sept 27, 191.7
20-UNDERTAKER	ADDRESS
J. A. Brown & Son	1818 W. Mad

Burial Permit

ROBERT R. KRAUTER

SEP 7 1917

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8793

CERTIFICATE OF DEATH.

17 D 8793

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Calvert ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Van Sant McNeal

(Residence in Baltimore: No. 729 Calvert St.; 71 yrs., 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White-American	Widower

6-DATE OF BIRTH, June (Month) 11 (Day), 1846 (Year)

7-AGE, 71 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Vice
(b) General nature of industry, business, or establishment in which employed (or employer): President B.&O.R.R.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James McNeal Jr.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Jane Goldsborough

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burton W. McNeal

(Address) 1919 Linden Ave

15-

Filed ....., 191.....

SEP 27 1917

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Sept 26 1917, that I saw him alive on Sept 26 1917, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Cerebral
Arteriosclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 26, 1917. (Address) 345 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Greenmount Cem	9-28, 1917
20-UNDERTAKER	ADDRESS
Henry McJenkins Sons Co	Orchard & Calhoun

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D-8794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-8794

CERTIFICATE OF DEATH.

x104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Keller

(Residence in Baltimore: No. 526- 14th St Highlandtown St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	✓

6-DATE OF BIRTH, October 2, 1916 (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Keller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Ehroff

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 25, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 24 1917, to Sept. 25 1917, that I saw h— alive on September 25 1917, and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Indigestion

.....

.....

..... (Duration).....yrs. 2 mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Henry R. Conrad M. D.

Sept. 26, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 526-14th St Highlandtown

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Sept. 27, 1917.

20-UNDERTAKER Lilly & Jules. — ADDRESS 403 S Wolfe

Duplicate Certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8795

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 8795

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Baltimore Gen Hosp

CITY OF BALTIMORE: (No. 1122 N. Monroe ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Morris

(Residence in Baltimore: No. 1804 Riggs Ave City St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct 22, 1836
(Month) (Day) (Year)

7-AGE, 80 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Harford Co. Md.

PARENTS.

10-NAME OF FATHER, Cardiff Morris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary F Hudnum

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Leonard Dunbaugh

(Address) 1906 Warren Ave

15-

Filed....., 191....

Registrar.

SEP 27 1917 ROBERT R. KRAUTER

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26 1917, to Sept 27 1917, that I saw him alive on Sept 26 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 2d. ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles E. Clark M. D.

Sept. 27, 1917. (Address) 1310 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State Life

Where was disease contracted, if not at place of death? 1804 Riggs Ave.

Former or usual residence 1804 Riggs Ave.

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL. Sept 29, 1917.

20-UNDERTAKER H. Parkhurst Jno

ADDRESS North

Dr Clark 1310 N Gilmor

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D. 8796

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Truck no 7 Union Station St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Wright

(Residence in Baltimore: No. 1237 Division St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH Dec 26 CR, 1858 (Month) (Day) (Year)

7-AGE, 58 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engr.
(b) General nature of industry, business, or establishment in which employed (or employer). R R 021

876

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sarah Chaney

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wright

(Address) 1237 Division st

15-

Filed SEP 27 1917, 191.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed by Cars -
Penna. R.R.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suddenness

(Duration) yrs. mos. ds.

(Signed) H. T. Kelly M. D. (Coroner.)

Sept. 27, 1917. (Address) 1637 Bonner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 27 1917

20-UNDERTAKER Geo H Holland ADDRESS 1631 Div Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8797

CERTIFICATE OF DEATH.

28 D. 8797

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 West ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Byrnes

(Residence in Baltimore: No. 1324 West St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Mar

6-DATE OF BIRTH, ... (Month) ....., (Day) 1887 (Year)

7-AGE, ...30....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cabbra
(b) General nature of industry, business, or establishment in which employed (or employer)..... General

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thomas Byrnes

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Anna Dempsey

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. K. Byrnes

(Address) 1329 West St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 25 1917, that I saw h[e] alive on Sept 24 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) 1 yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Dr Benedict M. D.

Sept 26, 1917. (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Sept 28, 1917

20-UNDERTAKER E. A. Friedfeld & Co — ADDRESS Greenmount Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8798 — 28 D 8798

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Frederick Ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Funk

(Residence in Baltimore: No. 1903 Frederick Ave St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 31 (Day), 1872 (Year)

7-AGE,	If LESS than 1 day,
45 yrs. 5 mos. 24 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer (Day) 140
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Grove Lumber Wagon

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Lewis Funk

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Lerain

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Louise Funk

(Address) 1903 Frdk Ave

15-

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Sept 23 1917, that I saw him alive on Sept 23 1917, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. Hill Hunnicutt M. D.

9/25, 191.7. (Address) 700 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 27 191.7.

20-UNDERTAKER Geo. L. Schwat Bro — ADDRESS 2101 Eutaw Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8799 — 91 D 8799

1 PLACE OF DEATH: Robert Garrett Hospital — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 27 Carey St. — ST.: 19 — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Helen A Quinn

(Residence in Baltimore: No. 1525 West Pratt St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH: Oct (Month) 14 (Day) 1916 (Year)

7-AGE: — yrs. 11 mos. 12 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 500

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: John C Quinn

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Jessie Smith

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jessie Quinn

(Address) 1525 W Pratt

15-

Filed....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17, 1917, to, Sept 26 1917, that I saw her alive on Sept 26 1917, and that death occurred, on the date stated above, at 3 00 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs — mos 23 ds

Contributory (SECONDARY): none

(Duration) — yrs — mos — ds

(Signed) John C Koch M. D.

Sept 26, 191 7. [Address] 27 N Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 9 ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death? Baltimore Md

Former or usual residence Baltimore Md.

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Sept 28, 191 7

20-UNDERTAKER: Wm J Fields — ADDRESS: 1200 W Fayette

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8800

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 Essex ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Kormazin

(Residence in Baltimore: No. 2325 Essex St. St.; 11 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ....., 1888 (Year) (Day)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer in Iron Foundry
(b) General nature of industry, business, or establishment in which employed (or employer)

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9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Michael Kormazin

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Michael Kormazin

(Address) 2325 Essex St.

15-

Filed ....., 191.....

SEP 27 1917 ROBERT L. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 26 1917, that I saw h[e] alive on Sept 26 1917 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

General Septicemia
Accessory Cause to Laceration of Finger (Duration) ..... yrs. now 4 mos. ..... ds.
CONTRIBUTORY (Secondary) Endocarditis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Sept 27 1917 (Address) 1005 Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Sept 2, 1917

20-UNDERTAKER W. F. Sadowski — ADDRESS 1705 S. Ann

GIVE ALL INFORMATION DESIRED in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Wm Wilson

D 8801 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 112 Division ST.: 17 WARD) REGISTERED No. C

2-FULL NAME William Wilson

(Residence in Baltimore: No. 1122 Division St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1886 (Year)

7-AGE, 31 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 1122 Division

15-

Filed ....., 191...

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 25, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Sept 27, 19...
20-UNDERTAKER David Easton	ADDRESS 916 Lanvale

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8802

CERTIFICATE OF DEATH.

113 D 8802

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N Gay ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lazarof

(Residence in Baltimore: No. 820 N Gay St

St.; ...yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, (Month) (Day) 1864 (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Furniture Merchant
(b) General nature of industry, business, or establishment in which employed (or employer), Ret

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Lazarof

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bilie Brokin

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Levis

(Address) 1411 E Balto

15- SEP 27 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Sept 26 1917, that I saw h in alive on Sept 26 1917, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J F Dolan M.D.

Sept 26, 191 7 (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herrn Rem

DATE OF BURIAL, 9/27 191 7

20-UNDERTAKER Jack Levors

ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8803

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Oxford St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther M. Evans

(Residence in Baltimore: No. 547 Oxford St. St.: 1.0 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, [redacted] (Month) (Day) 1865 (Year)

7-[redacted] 52 years .....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hostess
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Wilmington, Del

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Grupe

(Address) 547 Oxford St.

15-

Filed SEP 27 1917, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20th 1917, to Sept 26th 1917, that I saw him alive on Sept 25th 1917, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) 1 yrs. mos. ds.

(Signed) [illegible] M. D.

Sept 26, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hughesville Chas Co DATE OF BURIAL, 9-28 1917

20-UNDERTAKER John F. Soadwin ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8804

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 D 8804

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1407 Mt Royal Ave ST. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles D. Hubbard

(Residence in Baltimore: No. 1407 Mt Royal Ave St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 31 (Day), 1856 (Year)

7 AGE: 61 yrs. 1 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Hardware Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9 BIRTHPLACE (State or country): N.Y.

PARENTS

10 NAME OF FATHER: Daniel Hubbard

11 BIRTHPLACE OF FATHER (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary S. Fowler

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josephine Hubbard

(Address) 1407 Mt Royal Ave

15

Filed SEP 27 1917 191 .....

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 27 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1917, to Sept 27, 1917, that I saw him alive on Sept 26, 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 6 ds

Contributory (SECONDARY) Heart Insufficiency due to Nephritis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) H. B. Thomas M. D.

Sept 27, 1917 (Address) 1007 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Orange Va

DATE OF BURIAL: Sept 28, 1917

20 UNDERTAKER: John O Mitchell

ADDRESS: 1201 W Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 8805

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Anderson

(Residence in Baltimore: No. 532 McMechen St St.: — yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH. August 15, 1902
(Month) (Day) (Year)

7-AGE, 15 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harry W. Anderson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lily Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed SEP 2 1917, 191.... HARRY G. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept. 26 1917, that I saw her alive on September 26 1917, and that death occurred, on the date stated above, at 11.07 p m.

The CAUSE OF DEATH* was as follows:

Chorea Insaniens

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Wm. R. Rust M. D.

Sept 27 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 532 McMechen St

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, Sept 29, 191...

20-UNDERTAKER Lannon & Wright ADDRESS 361 Cary

D 8806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

704 D 8806

REGISTERED No. C

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE (No. Fountain ave & Madison ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winifred Virginia Lambert.

(Residence in Baltimore: No. Highfield Md St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, ... yrs. 7 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter E. Lambert

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Edith E. MacMullin

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter E. Lambert

(Address) Highfield Md

15-

Filed ....., 191.... HARRY C. ANDREWS Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY. .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

Sept 28, 191.7 (Address) 719 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 m ds. In the State ..... yrs. 7 mos. ..... ds.

Where was disease contracted, if not at place of death? Blue Ridge Summit

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Sept 28, 1917
20-UNDERTAKER	ADDRESS
Mr. Mrs Jno W. Leufel	801 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8807

CERTIFICATE OF DEATH.

26 D 8807

REGISTERED NO. C

1-PLACE OF DEATH,

CITY OF BALTIMORE: (No. 2043 Fleet St. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Walter Lo. Willey

(Residence in Baltimore: No. 2043 Fleet St.; St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Sept 4th, (Month) (Day) 1894 (Year)

7-AGE. 23 yrs. mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Lineman 086

(b) General nature of industry, business, or establishment in which employed (or employer). Gas Electric Co 463

9-BIRTHPLACE, (State or Country). York Pa

PARENTS.

10-NAME OF FATHER. Geo. Willey

11-BIRTHPLACE OF FATHER (State or Country). York. Pa

12-MAIDEN NAME OF MOTHER. Emma. Deitz

13-BIRTHPLACE OF MOTHER (State or Country). York. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eugene Willey

(Address) 2043 Fleet St.

15-

Filed SEP 27 1917, 191.... MARY C. ANDERSON Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1917, to Sept 26 1917, that I saw him alive on July 12 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jas. V. Lewton M. D.

Sept 26, 1917. (Address) 2235 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. ds. In the State 10 yrs. mos. ds.

Where was disease contracted, if not at place of death? Bethlehem, Md.

Former or usual residence 2043 Fleet

19-PLACE OF BURIAL OR REMOVAL. Prospect Cem. York Pa. DATE OF BURIAL. Sept 28 191 7.

20-UNDERTAKER. Olin Heaverow Sons ADDRESS York Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8803

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 E Fairmount ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adalaide A. E Elliott

(Residence in Baltimore: No. 2506 E Fairmount ave St.; 70 yrs.. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1845 (Year)

7-AGE, 72 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Auburn Maine

PARENTS.

10-NAME OF FATHER, Josiah W. Truman

11-BIRTHPLACE OF FATHER (State or Country), Unknown Maine

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Harold N. Mansell

(Address)..... 503 N. Luzerne ave

15-

Filed....., 191.....

Registrar.

SEP 27 1917 HARRY G. ANDREWS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 191 , to Sept 26th 1917, that I saw her alive on Sept 25th 1917, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration)..... yrs..... mos. 24 ds.

CONTRIBUTORY (Secondary) Hepatitis

..... (Duration)..... yrs..... mos. 2 1 ds.

(Signed) Elijah L Russell M. D.

Sept 27th, 191... (Address) 526 N. Mullins Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem'y	Sept 29, 191 7
20-UNDERTAKER Albert E Fuller	ADDRESS 221 N Bradley

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8809

CERTIFICATE OF DEATH.

114 D 8809

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Haltzman

(Residence in Baltimore: No. 1625 E. North Ave. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, August (Month) ..... (Day), 1858 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Geo. Haltzman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Kath. Keim

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. Haltzman

(Address) 1625 E. North Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1917, to Sept 25 1917, that I saw him alive on Sept 25 1917, and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Scrotum & Testis

Contributory

(Duration) Unknown yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. — mos. — ds.

(Signed) Wm. Ellis M. D.

Sept 25, 1917 (Address) Univ. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. mos. 20 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1625 E North Ave

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept. 28, 1917.

20-UNDERTAKER Ellis E Fuller ADDRESS 221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8810

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 D 8810

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3809 Hickory Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Gilbert Palmer

(Residence in Baltimore: No. 3809 Hickory Av St.; 1 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Baby

6-DATE OF BIRTH: March (Month) 28 (Day) 1916 (Year)

7-AGE: 1 yrs. 5 mos. 29 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Harry Palmer

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Mary E. Brown

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry E Palmer

(Address) 3809 Hickory Av

15- Filed SEP 27 1917, 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 26 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25, 1917, to, Sept 26 1917, that I saw h... alive on Sept 26 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ... yrs ... mos. 3 ds.

Contributory (SECONDARY) Enteritis

(Duration) ... yrs ... mos. 3 ds.

(Signed) R J Cannon M. D.

Sept 26, 191... [Address] 1201 N Carey

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Md

DATE OF BURIAL: Sept 28 1917

20-UNDERTAKER: Thomas W. Hess

ADDRESS: Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N. Fulton ave ST.; 15 WARD) REGISTERED No. C 120

2-FULL NAME Nathan Shulman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1801 N. Fulton ave St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1870 (Year)

7-AGE, 47 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Photographer
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Shulman

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elki Shapiro

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

SEP 27 1917 HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September 27 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1917, to death 191.....,
that I saw h[illegible] alive on Sept 25 1917,
and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. 6 mos. ds.

(Signed) S. Wolman M. D.

Sept 27 1917 (Address) 2407 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oheb Shalom — DATE OF BURIAL, 9/30, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

Please write plainly, as that is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 8812

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Blaney

(Residence in Baltimore: No. 110 S. Gilmor St St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-CONDITION. Married (Write the word.)

6-DATE OF BIRTH, Aug 26, 1873 (Month) (Day) (Year)

7-AGE, 44 yrs. mos. 30 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer) 054

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Blaney

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary A Gallagher

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Blaney

(Address) 2018 Gilmor St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 25, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Sept 25 1917, that I saw h[illegible] alive on Sept 25 1917, and that death occurred, on the date stated above, at 7 A.M. The CAUSE OF DEATH* was as follows:

Primary Pulmonary Tuberculosis (Acute Miliary) 2 wks

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Constipation - Insanity

(Duration) yrs. mos. ds.

(Signed) Myles B. Stanley M. D.

Sept 25, 1917 (Address) St Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 110 S. Gilmor St

19-PLACE OF BURIAL, OR REMOVAL, Mount Olivet Cem — DATE OF BURIAL, 9-28, 1917

20-UNDERTAKER Robert T. Brooks & Son — ADDRESS S. E. Cor Calhoun & Hollins sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8813

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 S Streeper St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Stefan Protosowic

(Residence in Baltimore: No. 1104 S Streeper St

St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 25, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Stefan Protosowic

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Josephine Kujawa

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stefan Protowic

(Address) 1104 S Streeper St

15-

Filed ....., 191.....

HARRY C. ANDREWS
SEP 27 1917 Registrar of Vital Statistics

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Sept 27 1917, that I saw h[illegible] alive on Sept 26 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo D Bullock M. D.

Sept 27, 191.. (Address) 2818 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem | DATE OF BURIAL, Sept 28, 191.7

20-UNDERTAKER Stephen J Fialkowski | ADDRESS 1018 Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8814

CERTIFICATE OF DEATH.

#D 8814

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N. Eden ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie B. Hill

(Residence in Baltimore: No. 1204 N. Eden St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. December 27th, 1870 (Month) (Day) (Year)

7-AGE. 46 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Teacher. 068
(b) General nature of industry, business, or establishment in which employed (or employer). Balto Public Schools

9-BIRTHPLACE. (State or Country). Elkton Md

PARENTS.

10-NAME OF FATHER. Joseph C. Hill

11-BIRTHPLACE OF FATHER (State or Country). Chester Co Pa

12-MAIDEN NAME OF MOTHER. Ruth A. Alexander

13-BIRTHPLACE OF MOTHER (State or Country). Cecil Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Marietta Hill

(Address) 1204 N. Eden st

15- SEP 27 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23 1917, to Sept 26 1917, that I saw h[illegible] alive on Sept 26 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

Contributory

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary). Secondary

(Duration) yrs. mos. ds.

(Signed) H. Hyde M. D.

Sept 27, 1917. (Address) 1100 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Sept 29th, 1917.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 8815

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Stirling ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Jones

(Residence in Baltimore: No. 607 Stirling St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Sept (Month) 10 (Day), 1876 (Year)

7-AGE. 41 yrs. ..... mos. 15 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Clara Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Clara A Jones

(Address) 607 Stirling St

15-

SEP 23 1917

Filed....., 191... ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1917, to Sept 24 1917, that I saw him alive on Sept 24 1917, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) .....yrs. 10 mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Robert J. Green M. D.

Sept 25, 1917. (Address) 120½ Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Sept 25, 1917.
20-UNDERTAKER Mrs R A Elliott	ADDRESS 506 East-St

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8816

CERTIFICATE OF DEATH.

50 ✓

D 8816

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs ~~Wolf~~ Dina Levin

(Residence in Baltimore: No. 1427 W. Baeto St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), (Day), 1881 (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of Industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin's

(Address) 1411 E. Baltimore St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 27 1917, that I saw her alive on Sept 27 1917, and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 1 ds.

(Signed) Bernard Jacobson M. D.

Sept 27, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1427 W Baltimore St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 9.28 191.7

20-UNDERTAKER Jack Levin — ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 28 1917 ROBERT B. KEASTER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8817

CERTIFICATE OF DEATH.

91 ✓ D 8817

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 N. Mount ST.; 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lipton Chapman

(Residence in Baltimore: No. 1405 N. Mount St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Baby

6-DATE OF BIRTH, Sept. 1, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. .. mos. 25 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Chapman

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Nina Lipton

13-BIRTHPLACE OF MOTHER (State or Country). Charlotte, N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Smith

(Address) 1405 N. Mount St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 29 1917, to to Sept 26 1917, that I saw him alive on September 26 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ... yrs. ... mos. 3 ds.

(Signed) Charles E. Clark M. D.

Sept. 27, 191.7 (Address) 1310 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. Sept 28 191.7

20-UNDERTAKER George H. Holland ADDRESS 1631 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 ✓ D 8813

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Willie Moss

(Residence in Baltimore: No. Johns Hopkins Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Write the word.) married

6-DATE OF BIRTH. September 1, 1861
(Month) (Day) (Year)

7-AGE. 56 yrs. 7 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Robt White Lead

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Margaret D Baldwin

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R A White Lead

(Address) 1521-23rd St NW Washington D.C.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25th, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6th 1917, to Sept 25th 1917, that I saw her alive on Sept 25th 1917, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas
with Chl. Retention
4
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. P. Batchelor M. D.
Sept 28 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. 1 ds.

Where was disease contracted, if not at place of death? Home.

Former or usual residence Markham, Va.

19-PLACE OF BURIAL OR REMOVAL. Markham Fauquier Co. Va

DATE OF BURIAL. Sept 26, 1917.

20-UNDERTAKER John B. Spence

ADDRESS 325 N Carlin St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 28 1917 ROBERT R. REAMER REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8819.

CERTIFICATE OF DEATH.

REGISTERED No. C D 8819.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 Mosher St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary McTague

(Residence in Baltimore: No. 1221 Mosher St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Mar

6-DATE OF BIRTH, Unknown; 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Clarke

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise McTague

(Address) 1221 Mosher St

15-

Filed SEP 28 1917, 191.... ROBERT E. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1915, to Sept 26 1917, that I saw h[er] alive on Sept 26 1917, and that death occurred, on the date stated above, at 1 AM (m.

The CAUSE OF DEATH* was as follows:

Cor Pulmonale
Arteriosclerosis
Chronic Nephritis
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Influenza Contracted
(Duration) ....yrs. ....mos. 2 ds.

(Signed) Chas P Plaisance M. D.

Sept 27, 191.7 (Address) 1504 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, Sept 30 191.7

20-UNDERTAKER Martin Fahey & Son ADDRESS Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8820

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

170 D 8820

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 525 S Ann ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick

(Residence in Baltimore: No. 525 S. Ann St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Oct. (Month) 4 (Day), 1860 (Year)

7-AGE,	If LESS than 1 day,
57 yrs. 11 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Michael Frederick

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Anna Wininger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mary Baker

(Address)..... 525 S. Ann St.

15-

SEP 22 1917

ROBERT P. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 27 1917, that I saw h[e] alive on Sept 27th 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

.....a
..... Cerebral Embolism
.....
..... (Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 3 yrs. ...mos. ...ds.

(Signed) ... Thomas J. Kelly M. D.

Sept. 22, 191... (Address) 1900 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Hill Park	Sept 29 191 7
20-UNDERTAKER Fickler & Fickler	ADDRESS 1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8821

CERTIFICATE OF DEATH.

47 ✓ D 8821

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1616 E. Chase ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin W. Henderson

(Residence in Baltimore: No. 1616 E. Chase St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb. 23 (Month) (Day), 1903 (Year)

7-AGE, 14 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry C. Henderson

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Maggie V. Keagle

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry C. Henderson

(Address) 1616 E. Chase

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10th, 191 7, to Sept 27 191 7, that I saw h im alive on Sept 27 191 7, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Chronic endocarditis

Arteriosclerosis & Nephritis

..... (Duration) about 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

..... (Duration) 5 yrs. mos. 2 ds.

(Signed) Edward Lambert M. D.

Sept. 27, 191 7. (Address) 1616 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem'y

DATE OF BURIAL, Sept. 30 191 7

20-UNDERTAKER Fickler Bros.

ADDRESS 1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8822

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Ward ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Audrey May Fink

(Residence in Baltimore: No. 1137 Ward St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 24 (Day), 1913 (Year)

7-AGE, 2 yrs. ..... mos. 3 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Raymond E. Fink

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Ethel May Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Kent Island Eastern Shore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Fink

(Address) 1137 Ward st

15-

SEP 28 1917

Filed....., 191.....

ROBERT P. FRANTZ

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25th 191.., to Sept 27 191.., that I saw h er alive on Sept 26th 191.., and that death occurred, on the date stated above, at 7.10 p.m.

The CAUSE OF DEATH* was as follows:

..... Bronchial Pneumonia

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Perlussis

..... (Duration) ....yrs. ....mos. 14 ds.

(Signed) J. A. Poulton M. D.

Sept 28, 1917. (Address) 654 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Sept 28 1917
20-UNDERTAKER, James Digman & Son	ADDRESS 100 S. Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

D 8823

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 W. Lexington ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vladeslow Glabus

(Residence in Baltimore: No. 735 W. Lexington St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 28, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Glabus

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Emma Buchus

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alpert Whitehead M.D.

(Address) 1128 Madison St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Vladeslo Glabus 1917, to Sept. 27 1917, that I saw h... alive on Sept 27 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Dry Stomach Indigestion

Enteritis Colitis

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Marasmus - Weakness

Diarrhea (Duration) ....yrs. 2 mos. ....ds.

(Signed) Alpert Whitehead M.D.

9-27, 1917. (Address) 1128 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislovas — DATE OF BURIAL, Sept. 29, 1917.

20-UNDERTAKER John Grebliauskas — ADDRESS 425 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

No D 8821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Asquith St.; 9 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Nellie D Evans

(Residence in Baltimore: No. 1825 Asquith St.; 57 yrs., 6 mos. 22 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 25 (Day) 1860 (Year)

7-AGE, 57 yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Adelia Feogales

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Elsie Evans

(Address) 1825 Asquith St

15-

Filed....., 191.....

ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 24 1917, to Sept 27 1917, that I saw her alive on Sept 27 1917, and that death occurred, on the date stated above, at 10.15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Unknown (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frances A. Caput M. D.

Sept. 25, 1917. (Address) 2101 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Sept 29th, 1917

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8825

CERTIFICATE OF DEATH.

28 ✓ D 8825

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Presbury ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rice

(Residence in Baltimore: No. 1605 Presbury St.; 6 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, January 18 th, 1911
(Month) (Day) (Year)

7-AGE, — yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at any
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Thomas Rice

11-BIRTHPLACE OF FATHER (State or Country), Anne Arundel Co, Md.

12-MAIDEN NAME OF MOTHER Louise Blunt

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Ireland

(Address) 1605 Presbury St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26 th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19th 1917, to Sept 26th 1917, that I saw him alive on Sept 26th 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Acute Tuberculosis Bronchio-pneumonia (Duration) — yrs. — mos. 7 ds.

(Signed) Wm T. Sellinger M. D.

9/27, 1917. (Address) 170 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, SEP 28 1917, 191...

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

SEP 28 1917 ROBERT N. KRAUTER

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1780 D 8826

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Shaffer.

(Residence in Baltimore: No. 427 S. Ellwood ave. St.; life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Sept (Month) 24 (Day), 1876 (Year)

7-AGE, 41 yrs. mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 109
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Clerk

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas. Shaffer

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Frances V. Barbar

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice M. Shaffer

(Address) 427 S. Ellwood ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21, 1917, to Sept 27, 1917, that I saw h[illegible] alive on Sept 1, 1917, and that death occurred, on the date stated above, at 7.56 p. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Suppression of Urine

(Duration) yrs. mos. 1 ds.

(Signed) H. A. Bowden M. D.

Sept 27, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State 41 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 427 S. Ellwood ave.

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet | DATE OF BURIAL, Sept 30, 1917

20-UNDERTAKER Wm. Cook | ADDRESS 702 E. Monument ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

977

SEP 28 1917 ROBERT R. KRAETER REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

Dr R. Cross 2438 Maryland Ave

D 8827

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 407 West 23rd St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Watts

(Residence in Baltimore: No. 467 W 23rd St.; Life yrs., mos. ds.)

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. 12, 1916 (Month) (Day) (Year)

7-AGE, — yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Wise

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sarah Watts

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas H Watts

(Address) 467 W. 23 Street

15-

SEP 28 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1917, to Sept 27 1917, that I saw h[illegible]ve on Sept 20 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Nervous exhaustion

(Duration) yrs. 4 mos. ds.

(Signed) Roscoe Cross M. D.

Sept 27, 1917 (Address) 2438 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Sept 29, 1917.

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

938 Ruth
Dudley

D 8828

HEALTH DEPARTMENT—CITY OF BALTIMORE

In front of 938

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

175 D 8828

REGISTERED NO. C

CITY OF BALTIMORE (No. Mt Calvert St. 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Knauff

(Residence in Baltimore: No. 938 Montpelier St.) 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 25 (Day) 1913 (Year)

7-AGE, 4 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child 600
(b) General nature of industry, business, or establishment in which employed (or employer) 600

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wilbur Knauff

11-BIRTHPLACE OF FATHER (State or Country), Baltimor Md

12-MAIDEN NAME OF MOTHER Mary Neigbler

13-BIRTHPLACE OF MOTHER (State or Country) Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William G Knauff

(Address) 433 East 20th Stet

15-

Filed....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull accidentally run over by Automobile (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. Norris Hundley M. D. (Coroner.)

July 27, 191.. (Address) 938 Montpelier St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimor Cemetery — DATE OF BURIAL, July 28 19..

20-UNDERTAKER William Cook — ADDRESS 507 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8829

CERTIFICATE OF DEATH.

28 D 8829

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 S. Monroe St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Eberle

(Residence in Baltimore: No. 124 S Monroe, St.; Lyrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Sept 1st, 1867 (Month) (Day) (Year)

7-AGE, 50 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm. Pennefield

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Fannie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Anne Hill md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olivia Eberle

(Address) 124 S. Monroe

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3, 191.., to Sept 27, 191.., that I saw her alive on Sept 26 191.., and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Sept 30th, 1917

20-UNDERTAKER Wm Cook — ADDRESS 502 E Mall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & ...—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8830

CERTIFICATE OF DEATH.

64 ✓ D 8830

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Harlem ad ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice A. Tinley.

(Residence in Baltimore: No. 1424 Harlem ad. St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH: Feb — (Month) (Day), 1853. (Year)

7-AGE: 64 yrs. 7 mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Dont Know.

11-BIRTHPLACE OF FATHER (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest E. Tinley.

(Address) 1424 Harlem ad

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27 (Month) (Day), 191? (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27, 191?, to Sept 27, 191?, that I saw h alive on Sept 27, 191?, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration 6 hrs

CONTRIBUTORY (Secondary) High blood pressure

Duration 5 yrs 6 mos ds.

(Signed) E E Tinley M. D.

Sept 27, 191? (Address) 1424 Harlem ad

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Sept 28 191?

20-UNDERTAKER: Wm Cook ADDRESS: No 6 E Hoff

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8831. HEALTH DEPARTMENT—CITY OF BALTIMORE 175 D 8831

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1710 Pulaski St., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur E Bailey

(Residence in Baltimore: No. 105 N Poppleton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Baby

6-DATE OF BIRTH, May 17, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 6 mos. 9 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER W B Bailey

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER Naomi Knedler

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W B Bailey

(Address) 103 Poppleton

15- SEP 28 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Jaundice
Cirrhosis of Liver (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident (Duration) yrs. mos. ds.

(Signed) J. Wm. Fowler M. D.
(Coroner)

Sept 28 191... (Address) 414 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Sept 28., 1917.
20-UNDERTAKER	ADDRESS
F. Flew McCulley	130 E. Fort Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8832

CERTIFICATE OF DEATH.

D 8832

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Elsinore Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maisie L. Yerby—

(Residence in Baltimore: No. 2206 Elsinore Av. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Aug 1 (Day), 1879 (Year)

7-AGE, 38 yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jesse W Dixon

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Minnie Dromberg

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse W Dixon

(Address) 2206 Elsinore Av

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1917, to Sept. 26 1917, that I saw h[er] alive on Sept. 26 1917, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory Tuberculosis

Pleura Thickening

(Duration) 21 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): General Asthenia

Tuberculosis (Duration) — yrs. — mos. — ds.

(Signed) J. W. Wilson Cole M. D.

SEP 28 1917

....., 191... (Address) 2202 Harrison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 29..., 191.7

20-UNDERTAKER W. J. Kuhns & Son

ADDRESS Camden & Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr J W Cole 2202 Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8833

CERTIFICATE OF DEATH.

79 D 8833

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 237 Colvin St. 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henriette Hamilton

(Residence in Baltimore: No. 237 Colvin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, Married 68 years (alive 51 years) ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Roger Armstrong

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ann. Fuchs.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Bulgell

(Address) Ensor St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cerebral

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. S. Tilley M. D.
(Coroner.)

Sep. 24, 191.7 (Address) 1619 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept 28, 1917
20-UNDERTAKER Charles B. Jones	ADDRESS 285 Pine St

SEP 28 1917 BOARD OF HEALTH BALTIMORE

Burial Permit

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8834 **CERTIFICATE OF DEATH.** 109 ✓ D 8834

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank. Snider.

(Residence in Baltimore: No. Henry Watson Society mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Baby

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191.....

ROBERT B. JOHNS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intussusception

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

Jan 26 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 hrs. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Henry Watson's Aid Society

Former or usual residence Henry Watson's Aid Society

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL. DATE OF BURIAL, SEP 28 1917, 19....

20-UNDERTAKER Commissioner Health. ADDRESS

Per. Wm. E. WOODALL.

SEP 28 1917

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8835

CERTIFICATE OF DEATH.

157 D 8835

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1454 Columbia ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Guthiel

(Residence in Baltimore: No. 1454 Columbia ave St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Dec (Month) 26 (Day), 1846 (Year)

7-AGE, 72 yrs. 9 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lineman 86
(b) General nature of industry, business, or establishment in which employed (or employer) Western Union Telegraph Co 359

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Guthiel

(Address) 1454 Columbia ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging

Suicidal

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dependancy due to ill health

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) James W Fenton M. D. (Coroner.)

Sept 27 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Sept 29th 1917

20-UNDERTAKER John J Cowan Son

ADDRESS 907 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8836

CERTIFICATE OF DEATH.

47 D 8836

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 Clifford St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gross.

(Residence in Baltimore: No. 833 Clifford St St.; 39 yrs., mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH: September 10, 1878
(Month) (Day) (Year)

7-AGE, 39 yrs. mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo. Grosp.

11-BIRTHPLACE OF FATHER (State or Country) Balto Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Alberta Gross

(Address) 833 Clifford St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 26 1917, that I saw h[illegible] alive on Sept 26 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

I Myocarditis

(Duration) .....yrs. .....mos. 20 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Sept 28, 1917

20-UNDERTAKER John Hoover & Son

ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 8837

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Albert

(Residence in Baltimore: No. 1514 Jefferson St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 240

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Gross

(Address) 1405 Mc Elderry St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1917, to Sept. 27 1917, that I saw h[illegible] alive on Sept. 27 1917, and that death occurred, on the date stated above, at 1 a, m.

The CAUSE OF DEATH* was as follows:

1 Hemiplegia 4 days

.....

.....

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. C. Peters M. D.

9/28, 191... (Address) 1520 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Asbury Cemetery — DATE OF BURIAL Sept 28, 1917

20-UNDERTAKER R. J. Gross — ADDRESS 1405 Mc Elderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 8838 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8838

CERTIFICATE OF DEATH.

10 8838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Magento

(Residence in Baltimore: No. 308 N. Exeter St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 23, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 0 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Chas. Magenta

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Carmella Carboy

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Phelps

(Address) Johns Hopkins Hosp.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27, 1917. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept. 25 1917. to Sept 27 1917. that I saw h alive on Sept. 27 1917. and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

gastro-intestinal indigestion

(Duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Conrad M. D.

Sept 27, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 308 N. Exeter St

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cem. DATE OF BURIAL, Sept 28 1917.

20-UNDERTAKER Lilly and Julian ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8839

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St Elizabeths Home ST.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Brisoe

(Residence in Baltimore: No. Lt. Elizabeths Home St.; 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, could not obtain ....., 1 .....
(Month) (Day) (Year)

7-AGE, 2 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed SEP 28 1917, 191.....

JOHNS
MARY C. ANDREWS
Social Service Worker
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19th 1917, to Sept 25 1917, that I saw h.. alive on Sept 25 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Probable General Miliary Tuberculosis,

(Duration) ....yrs....mos....ds.

(Signed) Frank J. Boyd M. D.

Sept 27, 1917. (Address) 1934 E. Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, SEP 28 1917, 191...

20-UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8810

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 8810

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 N. Poppleton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Norbert Peregoy.

(Residence in Baltimore: No. 729 N. Poppleton St.; ..yrs.. 10 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 8" (Month) (Day), 1916 (Year)

7-AGE, 1 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Peregoy

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Vola Howeman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Vola Peregoy

(Address) 729 N Poppleton St

15-

Filed SEP 28 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Sept 26 1917, that I saw h[illegible] alive on Sept 26 1917, and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as followa:

.....

Ileo-colitis

..... (Duration) ...yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Marasmus

..... (Duration) ...yrs. ...mos. 2 ds.

(Signed) J Harry Glassman M. D.

Sept 27, 1917 (Address) 2687 Mc Elderry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cem	Sept 29, 1917
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N Bulto Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8841

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8841

1 PLACE OF DEATH

REGISTERED No. C 10

CITY OF BALTIMORE (No. 1912 Christian St. 30 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ethel Louise Gorette

(Residence in Baltimore: No. 1912 Christian St St.: 1 yrs. 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct 31, 1915 (Month) (Day) (Year)

7 AGE: 1 yrs. 10 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Guy Gorette

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Daisy Litchfield

13 BIRTHPLACE OF MOTHER (State or country): Philadelphia Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Daisy Gorette
(Address) 1912 Christian St.

15 Filed SEP 28 1917, 191 ..... REGISTRAR

MARRIAGE AND DEATH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 28, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1916, to Sept 27, 1917, that I saw her alive on Sept 27, 1917, and that death occurred, on the date stated above, at 12 A m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Bronchitis (Chronic)

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) H M Robinson M. D.

Sept 28, 1917 (Address) 2010 Wilkens Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Oct 1st, 1917

20 UNDERTAKER: Geo. Lehmat & Bro — ADDRESS: 2101 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—20— Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8842

CERTIFICATE OF DEATH.

64 D 8842

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Madison ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miranda D. Stockdale

(Residence in Baltimore: No. 1017 Madison ave St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W Lite

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Oct 26 (Month) (Day), 1828 (Year)

7-AGE. 88 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Carroll Md

PARENTS.

10-NAME OF FATHER. Harley Bennett

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Sat Kimmey

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Connelly

(Address) 1017 Madison ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15th 1917, to Sept 26th 1917, that I saw h[illegible] alive on Sept 23rd 1917, and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

Senility

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Autopsy

..... (Duration) ..... yrs. ..... mos. 48 hrs

(Signed) Thomas A Kirk M. D.

Sept 28th 191.7. (Address) 1001 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Leutherdale Md

DATE OF BURIAL. Sept 29 191.7

20-UNDERTAKER Robt J Turner

ADDRESS 1142 W Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8843 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital 17 REGISTERED No. C

CITY OF BALTIMORE (No. ... St., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert King

(Residence in Baltimore: No. 225 N Durham, St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 27, 1885
(Month) (Day) (Year)

7-AGE 31 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver 623
(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream Co

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Wesley King

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Susie

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert King

(Address) 225 N Durham

15-

Filed SEP 28 1917, 191... ROBT. C. ANDERSON Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 26 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Asphyxia
Accidentally Struck
by Automobile Duration 1 yr. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) R. K. Gundry (Coroner.)

Sept 26 1917 (Address) 11 E. Lex St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Fayette & Pratt Sts

Former or usual residence 225 N Durham St.

19-PLACE OF BURIAL OR REMOVAL, Arbutus — DATE OF BURIAL, Sept. 29, 1917

20-UNDERTAKER Allen W Henderson — ADDRESS 21 N Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8843 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D 8843

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 157 W. Hamburg St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Lee (C)

(Residence in Baltimore: No. 157 W. Hamburg St. St.; //// yrs. 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored	Single.

6-DATE OF BIRTH, July 10th. 1917., /
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Roy Bell.(C)

11-BIRTHPLACE OF FATHER (State or Country) Virginia.

12-MAIDEN NAME OF MOTHER Edith Lee (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Lee.(C) grandmother.
157 W. Hamburg St.
(Address)

15-

Filed SEP 28 1917, 191 HARRY T. ANDREWS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diorrhoea.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Sept, 28, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn St	Sept. 29, 1917
20-UNDERTAKER	ADDRESS
L. G. Brown & Son	108 W. Monty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8845

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Shott Court. ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jones.(C)

(Residence in Baltimore: No. 1114 Shott Court. St.: yrs., 2 mos. 21 ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. AGE should be carefully applied. Exact statement of OCCUPATION is very properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, July 5th. 1917. (Month) (Day) / (Year)

7-AGE, -- yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert Jones.(C)

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Carrie Martin.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Jones.(C) mother.

(Address) 1114 Shott Court.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M Reinhardt M. D.
(Corner)

Sept. 28, 1917. 1017 S. Charles
191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn St	Sept 29 19.17
20-UNDERTAKER	ADDRESS
C. W. Brown & Son	108 W Monta

SEP 28 1917 HARRY G. ANDREWS Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D 8846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 8846

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 E. Chase - St.; W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann White

(Residence in Baltimore: No. 202 E. Chase St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widowed

6-DATE OF BIRTH, March 14, 1875
(Month) (Day) (Year)

7-AGE, 42 yrs. 6 mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), a a co Md

PARENTS.

10-NAME OF FATHER, Richard Edwards

11-BIRTHPLACE OF FATHER (State or Country), a a co Md

12-MAIDEN NAME OF MOTHER Rachel Garrett

13-BIRTHPLACE OF MOTHER (State or Country), a a co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Garrett

(Address) 116 S. Sarratoga St

15-

SEP 28 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Sept 27 1917, that I saw h e alive on Sept 26 1917, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:—

Bronchitis L. L.

(Duration) 1 yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Old Person

(Duration) ... yrs. ... mos. 14 ds.

(Signed) C. H. Horan M. D.

Sept 27 1917. (Address) 112 S. Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Ct	Sept 30, 1917.
20-UNDERTAKER	**ADDRESS.**
C. E. Brown & Son	1201 Penna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8847.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8847.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 Collins Ave ST.; 20 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Quinlin

(Residence in Baltimore: No. 150 Collins Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1859 (Year)

7-AGE 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Globe Brewery

782

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Michael Quinlin

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Ellen Dailey

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Delia Quinlan

(Address) 150 Collins Ave

15-

Filed ..... 191.....

SEP 24 1917 HARRY D. ANDREWS Registrar. Death Records Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1917, to Sept 26 1917, that I saw h[illegible] alive on Sept 25 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
Contracted Kidney
Myocardial Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W Jones M. D.

Sept 27, 1917. (Address) Irvington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, Sept 29, 1917.

20-UNDERTAKER K. C. Wiedefeld ADDRESS 614 Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8843

CERTIFICATE OF DEATH.

28 D 8843

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Ferry

(Residence in Baltimore: No. 225 S. Gilmor St.; Life time yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 21 (Day), 1893. (Year)

7-AGE, 24 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Patternmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Harry H. Ferry

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary A. Dowling

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H. Ferry

(Address) 225 S. Gilmor St.

15-

SEP 28 1917

Filed....., 191.... HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1917. (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1917, to Sept 27 1917, that I saw him alive on Sept 27, 1917, and that death occurred, on the date stated above, at 1.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary and Laryngeal Tuberculosis

(Duration) Over 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry C. Ohle M. D.

Sept. 28, 1917. (Address) 1223 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept. 30 1917.

20-UNDERTAKER John O'Mitchell — ADDRESS 1201 W Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8849

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1361 N Stricker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys M Holton

(Residence in Baltimore: No. 1361 N Stricker St. St.; 13 yrs., 7 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 2, (Day) 1904 (Year)

7-AGE, 13 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Clarence Holton

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Caroline Herbert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Herbert

(Address) 1364 N Stricker St

15-

Filed SEP 28 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 27th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1917, to Sept 27th 1917, that I saw h[illegible] alive on Sept. 25th 1917, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

(Duration) yrs. mos. ds.

(Signed) Geo. H. Saunders M. D.

Sept. 28th, 191.7 (Address) 2215 W. Fayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Sept 29, 1917

20-UNDERTAKER Clarence E Conaway

ADDRESS 1364 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8850

CERTIFICATE OF DEATH.

151

D 8850

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 W. Hoffman St.; 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Sinnett

(Residence in Baltimore: No. 547 W. Hoffman St.; ....yrs., ...mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col.	Infant

6-DATE OF BIRTH, Sept 26, 1917.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs....mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edward Sinnett

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Viola Martin

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Martin

(Address) 547 W. Hoffman St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1917, to Sept 28 1917, that I saw h[illegible] alive on Sept 27 1917, and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

General debility

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration)....yrs....mos....ds.

(Signed) W. H. Thompson M. D.

Sept 28, 1917. (Address) 1014 Pine St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn — DATE OF BURIAL, Sept 29, 1917.

20-UNDERTAKER John [illegible] Owens — ADDRESS 538 Dolphin St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8851

CERTIFICATE OF DEATH.

D 8851

18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 William St., WARD) 24

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick J. Duffy

(Residence in Baltimore: No. 1227 William St.; 50 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

24

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, aug (Month) 15 (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. 1 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

3 0 4 0

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Duffy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Wolden

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Duffy

(Address) 1227 William St.

15-

Filed....., 191....

Registrar.

SEP 28 1917

ALBERT C. ANDREWS
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Sept 26 1917, that I saw him alive on Sept 26 1917, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Empyema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) Jas. F. O'Donnell M. D.

Sept 28, 191... (Address) 1125 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	Sept. 29..., 1917

20-UNDERTAKER	ADDRESS
M. J. Flynn	422 Light St.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8852

CERTIFICATE OF DEATH.

151 D 8852

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 W. Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melba H. Hossfeld

(Residence in Baltimore: No. 2005 W Monroe St.; ___ yrs., ___ mos. 7 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Sept. (Month) 23 (Day) 1917 (Year)

7-AGE, ... yrs. ... mos. 7 ds. If LESS than 1 day, 22 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Chas. Hossfeld

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER, Hannah A. Lightner

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Charles Hossfeld

(Address) 2005 W. Monroe St

15-

Filed ..., 191...

Registrar.

HARRY O. ANDREWS
SEP 23 1917
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept. 28 1917, that I saw h[er] alive on Sept 27 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Asthenia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) ... yrs. ... mos. 1/2 ds.

(Signed) H. S. Mann M. D.

Sept. 28, 1917 (Address) 827 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Sept 28, 1917

20-UNDERTAKER Mrs. A. Rohde ADDRESS 823 N. Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 W. Baltimore ST.; 4 WARD)

REGISTERED NO. C 40

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anna M. Eschenbach.

(Residence in Baltimore: No. 626 W Baltimore St St.; 39 yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 7, 1858 (Month) (Day) (Year)

7-AGE, 58 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Doerstock

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Eschenbach

(Address) 626 W. Balto. St.

15-

Filed....., 191.....

Registrar.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 1917, to Sept. 26 1917, that I saw her alive on Sept 26 1917, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Disseminated Carcinoma.

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Gadderer M. D.

9/28/17, 191... (Address) 321 E. 25

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Sept 29, 1917

20-UNDERTAKER Henry A. Wittke — ADDRESS 1631 W. Lombard St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8854

D 8854

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 Stinson St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Sifers Jr.

(Residence in Baltimore: No. 337 Stinson St.; ..... yrs., 11 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, October 23rd, 1916
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo. L. Sifers

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Olga Beckman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. L. Sifers

(Address) 337 Stinson St

15-

Filed ..... 191.....

SEP 23 1917 HARRY C. ANDREWS Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 27 1917, that I saw him alive on Sept 27 1917, and that death occurred, on the date stated above, at 11 08 m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia and Whooping Cough

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Norbert Mutel M. D.

Sept 28, 1917. (Address) 2249 Mallory

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Sept 29, 1917

20-UNDERTAKER F. B. Hepburn

ADDRESS 223 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Michael Niemczyk

D 8855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8855

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 727 Broadway ST.: E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Niemczyk

(Residence in Baltimore: No. 727 E Broadway St.; 30 yrs., 1 mos. 9 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH. May 30 (Month) ....., 1887 (Day) (Year)

7-AGE, 30 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 023

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Andrew Niemczyk

11-BIRTHPLACE OF FATHER (State or Country). Germany Poland

12-MAIDEN NAME OF MOTHER. Mathilda Pechocki

13-BIRTHPLACE OF MOTHER (State or Country). Germany Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Niemczyk

(Address) 704 S. Durham St.

15- SEP 29 1917 ROBERT E. KRAUTER

Filed....., 191.. .....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Henry Ky. M.D. (Coroner.)....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of denth.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Oct 1st, 19.17.

20-UNDERTAKER W. F. Saelens Co. ADDRESS 905 S. Ann St.

D 8856

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1755 ✓ D 8856

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 43 St. Margaret's WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A Reuter

(Residence in Baltimore: No. 2433 Frances st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mard

6-DATE OF BIRTH, Oct 13, 1846
(Month) (Day) (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) 078

54 ✓

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Fredk Reuter

11-BIRTHPLACE OF FATHER (State or Country), Gad,

12-MAIDEN NAME OF MOTHER Elizt Conley

13-BIRTHPLACE OF MOTHER (State or Country), Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C Reuter

(Address) 2433 Frances

15-

Filed SEP 29 1917, 191.

ROBERT R. KRAETER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 28, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration, Contusion, Internal injuries, Car struck by car, Instantaneous.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Lundberg M. D.
(Coroner.)

191... (Address) 911 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct. 1..., 1917

20-UNDERTAKER Josiah Leyh

ADDRESS 1600 W North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8857

1-PLACE OF DEATH Robert Garrett Hospital — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 27 N. Gorey St. St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Muller

(Residence in Baltimore: No. 107 Charles Ave. St.; Hamilton yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: February 8 (Month) (Day), 1916 (Year)

7-AGE: 1 yrs. 7 mos. 21 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Baltimore Co. Md

PARENTS

10-NAME OF FATHER: Gabriel Muller

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary E. Bertling

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gabriel Muller

(Address) 107 Charles Ave Hamilton

15-

Filed SEP 29 1917, 191 ..... ROBERT B. KRAUTER REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3, 1917, to, Sept 29 1917, that I saw him alive on Sept 28 1917, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Colitis

(Duration) — yrs. 1 mos. 6 ds.

Contributory (SECONDARY) Improper Feeding

(Duration) — yrs. 3 mos. — ds.

(Signed) John C. Krock M. D.

Sept. 29, 1917 [Address] 27 N. Gorey St

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. 26 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Hamilton Md.

Former or usual residence Hamilton Md

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct. 1st, 1917

20-UNDERTAKER: George F. Routh — ADDRESS: 1735 Hayford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8858

CERTIFICATE OF DEATH.

1548 8858

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mollie appold

(Residence in Baltimore: No. 2800 Walbrook Ave St.; 60 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb 14, 1837 (Month) (Day) (Year)

7-AGE, 80 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Co. Md

PARENTS.

10-NAME OF FATHER, John Mackenzie

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Emily January

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mollie Keller

(Address) 2800 Walbrook Av

15- SEP 29 1917 ROBERT B. KRAUTER

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 25 1917, to Sept 27 1917, that I saw h... alive on Sept 26 1917, and that death occurred, on the date stated above, at 1130 p m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardeos asthma

(Duration) yrs. 1 mos. 14 ds.

(Signed) Herbert E Cupp M. D.

Sept 28, 1917. (Address) 301 S N North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Presbyterian Cemetery Govans — DATE OF BURIAL, Sept 30 191 7.

20-UNDERTAKER, H. C. Wadefield — ADDRESS 914 Fremont Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8859

CERTIFICATE OF DEATH.

104 D 8859

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 602 S. Montford Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Meurer Jr

(Residence in Baltimore: No. 602 S. Montford Ave St. Lyrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 2, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, William E. Meurer

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md.

12-MAIDEN NAME OF MOTHER Elizabeth Hellschlagen

13-BIRTHPLACE OF MOTHER (State or Country), Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Meurer

(Address) 602 S. Montford Ave

15-

Filed ....., 191....

SEP 29 1917 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Sept 27 1917, that I saw him alive on Sept 27 1917, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas Boyd M. D.

Sept 27, 1917. (Address) 602 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Sept 29, 1917.
20-UNDERTAKER	ADDRESS
H. Sanders Sons	16 E. Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

176 D 8860

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mahr

(Residence in Baltimore: No. 2814 E. Baltimore St. St.; 4yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, or DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, Mar. 18, 1845
(Month) (Day) (Year)

7-AGE, 72 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Peter Mahr

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Rausch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Friend

(Address) Mercy Hosp.

15-

SEP 29 1917

Filed....., 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 13 1917, to Sept. 28 1917, that I saw him alive on Sept. 28 1917, and that death occurred, on the date stated above, 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Hypernephroid Tumor of Kidney

abt. 2 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

abt. (Duration) yrs. 5 mos. 15 ds.

(Signed) Edward V. Smith M. D.

Sept. 28, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2814 E. Balto St.

Former or usual residence 2814 E. Balto St.

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Oct. 1, 1917.

20-UNDERTAKER H. Sauder & Sons — ADDRESS 110 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8861

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 D 8861

REGISTERED NO. C.....

1 PLACE OF DEATH Robert Garrett Hospital

CITY OF BALTIMORE: (No. 27 W. Carey ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Hullett

(Residence in Baltimore: No. 2836 W. Lanvale St.; yrs. 9 mos. 14 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: December 15 (Month) (Day), 1916 (Year)

7-AGE: — yrs. 9 mos. 14 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Edgar F Hullett

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Sarah R. Hall

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar F Hullett

(Address) 2836 W Lanvale St

15- ROBERT R. BRAUER
SEP 29 1917 Burial Permit Clerk

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1917, to, Sept. 29 1917, that I saw him alive on Sept. 28 1917, and that death occurred, on the date stated above, at 12 20 a. m.

The CAUSE OF DEATH* was as follows:

Diverticulitis

(Duration) — yrs — mos. 7 ds.

Contributory (SECONDARY) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Cook M. D.

Sept 29, 1917 [Address] 27 W. Carey St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Baltimore Md

Former or usual residence Baltimore Md 2836 W Lanvale St

19-PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: Sept 30, 191

20-UNDERTAKER: Jos L Cook — ADDRESS: 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8862

CERTIFICATE OF DEATH.

28 D 8862

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Fernhill ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Adelaide Hauser

(Residence in Baltimore: No. 4002 Fernhill ave St.; ....yrs,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August 15th, 1896
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 1 mos. 11 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Paul C. E. Hauser

11-BIRTHPLACE OF FATHER (State or Country), Phila - Pa.

12-MAIDEN NAME OF MOTHER Ida E. Rinse

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul C. E. Hauser

(Address) 4002 Fernhill Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 11th 1917, to September 26 1917, that I saw h[illegible] alive on September 26 1917, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 7 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robt. F. Murray M.D. M. D.

Sept. 27, 191 7 (Address) 510 N. Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 9-30, 191 7

20-UNDERTAKER H. Brauning & Son

ADDRESS 517 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8863

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 8863

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH 203

CITY OF BALTIMORE: (No. 203 W Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Derry

(Residence in Baltimore: No. 203 W Hamburg St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1878 (Year)

7-AGE, 38 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Balto. city

PARENTS.

10-NAME OF FATHER, Robert Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Spence

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Derry

(Address) 203 W Hamburg St

15-

SEP 29 1917 ROBERT B. KRAUTER Registrar

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1917, to Sept 27 1917, that I saw h[illegible] alive on Sept 26 1917 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dotemia

2 m a (Duration) 0 yrs. 2 mos. 0 ds.

(Signed) Edward F. Yates M. D.

Sept 27 1917. (Address) 1612 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 9-30, 1917

20-UNDERTAKER Jas A. Bradley

ADDRESS 142 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8861

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 V D 8861

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2019 N. Charles ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Ignatius Clark

(Residence in Baltimore: No. 2019 N. Charles St- St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 23 (Day), 1851 (Year)

7-AGE, 66 yrs. 4 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): Self 04

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James A. Clark

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Elizabeth Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Frances N. Clark
(Address) 2019 N. Charles St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/23 1917, to 9/28 1917, that I saw him alive on 9/28 1917, and that death occurred, on the date stated above, at 9:20 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrage
R. Hemiplegia
(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY. Arteriosclerosis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

9/28, 1917. (Address) 2019 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Oct. 1, 1917

20-UNDERTAKER Millard F. Jones

ADDRESS 51 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

764

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8865

CERTIFICATE OF DEATH.

90 ✓ D 8865

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 N. Washington ST.; 8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria L. Holland

(Residence in Baltimore: No. 1512 N. Washington St.; Left yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept 11 (Month), (Day), 1837 (Year)

7-AGE, 80 yrs. — mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work 000 (b) General nature of industry, business, or establishment in which employed (or employer) 000 None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H O'Hara

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Holland

(Address) 1512 N. Washington

15- ROBERT R. KRAETER SEP 29 1917 Registrar.

Filed ....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1917, to Sept. 27, 1917, that I saw her alive on Sept. 26, 1917, and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Fenby M. D.

Sept. 28, 1917. (Address) 1223 N. Carolina st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Sept 30, 191..

20-UNDERTAKER Robt J Turner

ADDRESS 1442 N Broadway

Spec.—8-24-14—M. —2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8866

CERTIFICATE OF DEATH.

D 8866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213. E. 25th St.; 17 Ward) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M Stewart

(Residence in Baltimore: No. 213. E. 25th St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Feby 22, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 7 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House 031
(b) General nature of industry, business, or establishment in which employed (or employer). wife

BIRTHPLACE, State or Country). Baltimore Md

10-NAME OF FATHER. John W Hartline

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Clara D Maguette

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter V Stewart

(Address) 213 E 25th St

15-

Filed....., 191.....

Registrar.

SEP 29 1917 ROBERT D. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1917, to Sept 27 1917, that I saw her alive on Sept 27 1917, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ....yrs. ....mos. 24 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J K Gorsuch M. D.

Sept 29, 1917. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Loraine Cemetery DATE OF BURIAL. Sept 30, 1917

20-UNDERTAKER Clark & Sinner ADDRESS 1142 N Broadway

important. See instructions on back of OCCUPATION is very

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8867

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

17 D 8867

REGISTERED NO. C

CITY OF BALTIMORE (No. 303 W. Lanvale St.; 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Norris Hall

(Residence in Baltimore: No. 303 W. Lanvale St.; 1 yrs., — mos. 25 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widowed

6-DATE OF BIRTH: November (Month), (Day), 1849 (Year)

7-AGE: 67 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None, Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): Home Keeping

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Not Known Boyle

11-BIRTHPLACE OF FATHER (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Charlotte Norris Boyle

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willoughby Hall

(Address) 303 W. Lanvale St.

15-

Filed ..... 191 .....

Registrar.

SEP 29 1917 ROBERT R. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept. 28 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

Chronic (Duration) 4 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner) Sept 29 191 (Address) 19 W. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 10-1 1917

20-UNDERTAKER: Lenz & Henkins & Son Co.

ADDRESS: Orchard & McCulloh

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8868 ✓ D 8868

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Hoffd

(Residence in Baltimore: No. 731 S. Glover St St.: 6 yrs., 1 mos. 15 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug 13 00, 1901.
(Month) (Day) (Year)

7-AGE, 6 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Frederick Hoffd.

11-BIRTHPLACE OF FATHER (State or Country), Balto - Md.

12-MAIDEN NAME OF MOTHER Rosa Sadowske

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 28, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1917, to Sept. 28 1917, that I saw h m alive on Sept. 28 1917, and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Convulsions (cause unknown)

(Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) 0 yrs. 0 mos. 2 ds.

(Signed) Henry B. Conrad M. D.

Sept 28 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 731 S. Glover St

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Oct. 1 1917.

20-UNDERTAKER Lilly & Geiler

ADDRESS 403 S. Wolfe St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 8869

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 422 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin H. Engelhardt

(Residence in Baltimore: No. 422 S. Ann St.; ....yrs., 5 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. April 29th, 1917
(Month) (Day) (Year)

7-AGE. ....yrs. 5 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Engelhardt

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Bertha D. Marshall

13-BIRTHPLACE OF MOTHER (State or Country). Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Frank Engelhardt

(Address). ~~422 S. Ann St~~

15- 1929 Gough St.

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 191 7, to Sept 28 191 7, that I saw h m alive on Sept 28 191 7, and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as followa:

Gastro E nteritis 2 days with

.....

.....

..... (Duration) ....yrs. ~~12~~ mos. 12 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) Thos. A. Hubbard M. D.

10-12, 191 7 (Address) 1631 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mount Carmel

DATE OF BURIAL. Sept 30, 1917.

20-UNDERTAKER Lilly - Zeiler

ADDRESS 405 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 D 8870

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home St. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno 6 Wrzesinski

(Residence in Baltimore: No. 510 Paca St.

S.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mat

4-COLOR OR RACE, whi

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Marr'd

6-DATE OF BIRTH, July, 1

(Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Wojciech Wrzesinski

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), ———

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Wrzesinski

(Address) 714 Aisquith

15- SEP 29 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Farnham M. D.
(Coroner.)

Sept 29 1917. (Address) 11 E. Lexington

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 27 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct 2, 1917

20-UNDERTAKER Wm Hallowell's

ADDRESS 618 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 8871

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 8871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 W. Pratt St. ST.; 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Murray

(Residence in Baltimore: No. 1840 W. Pratt St. St.; 37 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 17 (Day), 1880 (Year)

7-AGE, 50 yrs. 5 mos. 11 days. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Washington D. C.

PARENTS.

10-NAME OF FATHER, Howard Murray

11-BIRTHPLACE OF FATHER (State or Country), Washington D C

12-MAIDEN NAME OF MOTHER Anna ?

13-BIRTHPLACE OF MOTHER (State or Country), Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Murray

(Address) 1840 W Pratt

15-

Filed SEP 29 1917, 191.... ROBERT E. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/1 1917, to 9/28 1917, that I saw h[illegible] alive on 9/28 191., and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 28 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward L. Burns M. D.

....., 191... (Address) 1 Mount Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. 41 ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence 1840 W Pratt

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem DC	Oct 2, 191.

20-UNDERTAKER	ADDRESS
Williams Cook	501 N Gay

D 8872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 ✓ D 8872

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 111 Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evangeline Spriggs

(Residence in Baltimore: No. 111 Vincent St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Feb (Month) 14 (Day), 1917 (Year)

7-AGE, ...yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Spriggs

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Matilda Green

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Spriggs

(Address) 111 Vincent St

15-

Filed SEP 29 1917, 191.....

ROBERT R. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Improper diet

(Duration) ....yrs. 6 mos. ....ds.

(Signed) James M Faulkner M. D. (Coroner.)

Sept 28 1917. (Address) 7 W Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Sept 29, 1917
20-UNDERTAKER Wilbert Brown	ADDRESS 1141 N. Schroeder St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8873

D 8873

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 Lamvale ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Alone Mahaffey,

(Residence in Baltimore: No. 142 Lamvale St. St.; 28 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 22 (Day), 1840 (Year)

7-AGE, 77 yrs. 5 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... House Work .....

9-BIRTHPLACE, (State or Country), Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER, ~~Harry~~ Harry Dinsmore

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Mullen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis H. Mahaffey

(Address) 1404 Union Ave

15-

SEP 29 1917

Filed....., 191.....

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 27 1917, that I saw h.. alive on September 27 1917, and that death occurred, on the date stated above, at 11-55 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Senility Etc.

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Cathell M. D.

Sept 28, 1917 (Address) Emerson Hotel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery Phila. Pa. DATE OF BURIAL, Oct ....., 1917.

20-UNDERTAKER Henry W. Deas & Son ADDRESS 1058 Cathedral St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 8874

REGISTERED NO. C.....

1-PLACE OF DEATH Old Age Home

CITY OF BALTIMORE: (No. 109 Aisquith ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Bellert

(Residence in Baltimore: No. 109 Aisquith St.; 40 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Shimberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Parisen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Bellert.

(Address) 500 N. Pulaski St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1915, to Sept. 27, 1917, that I saw h[er] alive on Sept. 27, 1917, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

Uremia - Tetanus

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) D. G. McCutcheon M. D.

Sept. 28, 1917. (Address) 1122 E Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Old Age Home

19-PLACE OF BURIAL OR REMOVAL, Hebrew Blair Rd Cemetery DATE OF BURIAL, Sept 30, 1917.

20-UNDERTAKER S. Levinson & Co ADDRESS 417 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8875

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 D 8875

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 Jackson place ST. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomi Snyder

(Residence in Baltimore: No. 124 Jackson Place St.; ... yrs. ... mos. 15 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: Sept. 27th, 1917 (Month) (Day) (Year)

7-AGE: ... yrs. ... mos. 15 ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): 124 Jackson place

PARENTS

10-NAME OF FATHER: Dave Snyder

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Mamie Snyder

13-BIRTHPLACE OF MOTHER (State or country): U-S-A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dave Snyder

(Address) 124 Jackson St

15.

Filed ... 191 ... ROBERT R. KRAUTER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. 29th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1917, to Sept. 29 1917 that I saw h-as- alive on Sept 28 1917 and that death occurred, on the date stated above, at 4 AM. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

... (Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) M. V. Kelly M. D.

Sept 29, 1917 (Address) 1761 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence 124

19-PLACE OF BURIAL OR REMOVAL: Hebrew Union Fe | DATE OF BURIAL: Sept 29 1917

20-UNDERTAKER: A. Levinson & Bro | ADDRESS 11[illegible] Balto

D. 8876 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8876

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. University Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Price

(Residence in Baltimore: No. 402 N. Greene St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 9 (Day), 1880 (Year)

7-AGE, 37 yrs. 3 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sales-Lady
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Johnstown Pa.

PARENTS.

10-NAME OF FATHER, Henry Price

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Catherine Jenkins

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman Price

(Address) Johnstown Pa.

15-

Filed SEP 30 1917, 191.....

ROBERT B. KRAUTER
Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Albert D. Driscoll. M. D. (Coroner)

Sept 29, 1917. (Address) 312 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT ARRIVALS)

At place of death.....yrs.....mos. 1 ds. State 5 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 402 N. Greene St.

19-PLACE OF BURIAL OR REMOVAL, Johnstown Pa — DATE OF BURIAL, Sept 30, 19 17

20-UNDERTAKER Joseph J Cook — ADDRESS 1003 W Baltimore St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8877

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8877

CERTIFICATE OF DEATH

1 PLACE OF DEATH House of Good Shepherd — REGISTERED NO. C 1979

CITY OF BALTIMORE (No. Monument St — St. — WARD 19) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Kelly

(Residence in Baltimore: No. House of Good Shepherd St.: yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

Female — Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 29th (Month) (Day), 1850 (Year)

7-AGE: 67 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Richmond

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sisters of Good Shepherd

(Address) .....

15- In the House 41 years

Filed — , 191 ROBERT R. FRAZIER REGISTRAR

SEP 30 1917 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 29th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1917, to Sept 29th, 1917, that I saw h[illegible] alive on Sept 26th, 1917, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of The Heart — Unknown

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Death Sudden

(Duration) yrs. mos. ds.

(Signed) E. J. Nicholl M. D.

....., 191..... (Address) 1934 Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peters Cem — DATE OF BURIAL: Sept 30, 1917

20-UNDERTAKER: Geo Fahey & Son — ADDRESS: 318 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8878

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 8878

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 E Madison ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michele Russo.

(Residence in Baltimore: No. 909 E Madison St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Sept. 16, 1917
(Month) (Day) (Year)

7-AGE, 13 Days
....yrs....mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Agostino Russo

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Carmela Piava

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Libertino

(Address) 1307 Jefferson st.

15-

Filed SEP 30 1917, 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 1917, to Sept. 28 1917, that I saw him alive on Sept. 28 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Suffocation

..... (Duration) ....yrs. ....mos. 3 ....ds.

CONTRIBUTORY (Secondary) Acute Bronchitis and Pneumonia (Duration) ....yrs. ....mos. 10 ....ds.

(Signed) E. Palmisano M. D.

Sept. 29, 191.. (Address) 1365 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, Sept. 30, 191.7

20-UNDERTAKER George J. Reuth

ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8879

CERTIFICATE OF DEATH.

81

D 8879.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 Dolphin St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Fannie Green

(Residence in Baltimore: No. 555 Dolphin St.; 65 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... September ....., 1 ..... (Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000 000

9-BIRTHPLACE, (State or Country) Charlotte Hall Md

PARENTS.

10-NAME OF FATHER, Yarnall Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Ann Foy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Grace Johnson

(Address) 555 N. Dolphin

15-

SEP 30 1917 ROBERT B. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1917, to Sept. 26 1917, that I saw h er alive on Sept. 25 1917, and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio — Sclerosis.

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) W. S. Carr, Jr. M. D.

Sept 29, 1917. (Address) 516 Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem — DATE OF BURIAL, Sept 30, 1917.

20-UNDERTAKER, Samuel Hussey — ADDRESS 518 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

D 8880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 McElderry St. 5 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Shapiro

(Residence in Baltimore: No. 1232 McElderry St.; 11 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1 (Year)

7-AGE, 72 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cap Maker
(b) General nature of industry, business, or establishment in which employed (or employer):

4-70 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Schapiro

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

SEP 30 1917 ROBERT E. KRAUTER BURIAL PERMIT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 28 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 5 1917, to Sep 28 1917, that I saw h[illegible] alive on Sep 28 1917, and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 3 yrs. mos. ds.

(Signed) M. Bayliss M. D.

Sep 28, 191.. (Address) 21 Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herrun Run

DATE OF BURIAL, 9/30, 191..7

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

D 8831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8831

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Ashburton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ford E. Shipley

(Residence in Baltimore: No. 1810 Ashburton St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov. (Month) 10 (Day), 1846 (Year)

7-AGE, 70 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of Industry, business, or establishment in which employed (or employer): B & O R R Co

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob Shipley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Seymour

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Shipley

(Address) 1810 Ashburton St

15-

Filed....., 191....

SEP 30 1917 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1" 1917, to Sept 28 1917, that I saw him alive on Sept 27" 1917, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. 6 mos. 28 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ....yrs. ....mos. 30 ds.

(Signed) Herbert E. Bate M. D.

Sept 29, 1917. (Address) 3050 N. Month Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 1, 191 7

20-UNDERTAKER W. H. Eichmeyer

ADDRESS Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8882

CERTIFICATE OF DEATH.

64 152

D 8882

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Rea

(Residence in Baltimore: No. 1106 Harlem Ave. St.; .....yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 15 (Month) 1917 (Day) (Year)

7-AGE, ...yrs. 14 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 200
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Arthur Rea.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ethel Fuerke

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Myers

(Address) Johns Hopkins Hosp

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 29, (Day) 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Sept 29 1917., that I saw him alive on Sept 29 1917. and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Birth injury)

(Duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) 0 yrs. 0 mos. 14 ds.

(Signed) Henry B. Conrad M. D.

Sept 29 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. 14 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 1106 Harlem Ave.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 30, 1917.

20-UNDERTAKER W. J. Todhunter

ADDRESS Madison Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D 8883

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4344 Whitelock ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donald Fred Curry

(Residence in Baltimore: No. 4344 Whitelock St.; yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 8, 1915
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....000
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clyde Curry

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Anna Schustman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde Curry

(Address) 4344 Whitelock

15-

SEP 30 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Sept 28 1917, that I saw h[illegible] alive on Sept 28 1917, and that death occurred, on the date stated above, at 11.38 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ....yrs. 1 mos. 15 ds.

(Signed) [illegible] M. D.

Sept 29, 1917. (Address) 112 W. 23rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Oct 1, 1917.

20-UNDERTAKER Frank Cook

ADDRESS Park North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8884

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 N. Fulton ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loretta E. Sturm

(Residence in Baltimore: No. 6 N. Fulton St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, May 25, 1897 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
20 yrs. 7 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): U.S.F.S. Co

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm. A. Sturm

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elizabeth A Krause

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. Sturm

(Address) 6 N. Fulton av

15-

SEP 30 1917

ROBERT R. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1916, to Sept 29 1917, that I saw h- alive on Sept 29 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) E. V. Cookman M. D.

Sept 30, 1917. (Address) 24 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Sept 1, 1917.
20-UNDERTAKER	ADDRESS
P. A. Krause	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P 17
3 / D 8885

HEALTH DEPARTMENT—CITY OF BALTIMORE

+175 D 8885

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fd. Ground Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Mohler

(Residence in Baltimore: No. 601 S. 14 St.; Pt. Highland Town yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 16 (Day), 1897 (Year)

7-AGE, 20 yrs. 3 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of Industry, business, or establishment in which employed (or employer): R.R. 073

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Harry E. Mohler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma M Perkins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) 601 S. 14th St

15- Highland Town

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock from operation for Lacerations of Thigh

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 8 ds.

(Signed) J. Mahlon Kemp (Coroner.) M. D.

(Address) 8 E 9th Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Barnesville Md DATE OF BURIAL, Oct 1., 1917

20-UNDERTAKER H. Sander & Sons ADDRESS 1710 Pleet St

Enml

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

529

D 8886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X175 D 8886

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hosp ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J Stumpf

(Residence in Baltimore: No. Maple ave & Harford Ave St.; yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, July 18, 1881
(Month) (Day) (Year)

7-AGE, 36 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo A Stumpf

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Friedericka Hagemann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Stumpf

(Address) Maple Av

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by a Street Car (Accidental)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Fracture of skull, Con. cussion of brain (Duration) .....yrs.....mos.....ds.

(Signed) H. Colvert Truitt M. D.
(Coroner)

9/29, 1917. (Address) 710 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 4 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, SEP. 30 1917

20-UNDERTAKER Geo A Gertig

ADDRESS Gilmor & Pay Av 86

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8887

CERTIFICATE OF DEATH.

41

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Kenwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura G. Battersby

(Residence in Baltimore: No. 520 S. Kenwood ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... April 10 ....., 1878
(Month) (Day) (Year)

7-AGE, 39 yrs. 5 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry E. Sullivan

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary E. Van Bokern

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. G. Battersby

(Address) 520 S. Kenwood Ave.

15-

Filed....., 191.....

SEP 30 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23 191, to Sept 27 191?, that I saw h.. alive on Sept 27 191?, and that death occurred, on the date stated above, at 4 36 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... Intestinal Carcinoma

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

9/29, 191?. (Address) 1201 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, Oct 1 ....., 191?.

20-UNDERTAKER Lilly + Zeeler

ADDRESS 403 S. Wolfe

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8893

CERTIFICATE OF DEATH.

108 D 8893

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Prot Infirmary ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Roche

(Residence in Baltimore: No. 2730 Wilkens ave St.; ..... yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	married

6-DATE OF BIRTH, ... Mar (Month) 17 (Day) 1860 (Year)

7-AGE, ...57.... yrs. ....6.. mos. ..13.. ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 080

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Roche

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Miss May Maloney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Keeley M D

(Address) U P H

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1917, to Sept 30 1917, that I saw him alive on Sept 30 1917, and that death occurred, on the date stated above, at 1.12 m.

The CAUSE OF DEATH* was as follows:

Operation for Appendicitis Aug 25
Intestinal Obstruction Sept 23
Operation Sept 23rd (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J R Micklethwaite M. D.

Sept 30 1917 (Address) U P H

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 36 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2730 Wilkens ave

19-PLACE OF BURIAL OR REMOVAL, Cathedral Stem DATE OF BURIAL, Oct 1, 1917

20-UNDERTAKER Chas E Evans & Son ADDRESS 118 W Mt Royal ave

N. B.—Entries on this certificate should be clearly written, ACCURATE and COMPLETE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 30 1917 ROBERT R. KRAUTER REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8889

D 8889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 S. Robinson ST.; 1st WARD)

REGISTERED NO. C 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Virginia Clark

(Residence in Baltimore: No. 820 S. Robinson St.; yrs. 16 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, (Month) Nov. (Day) 9th, (Year) 1900

7-AGE, yrs. 16 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Edward P. L. Clark

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Margaret Jary

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret L. Clark

(Address) S. 820 S. Robinson St.

15-

Filed SEP 30 1917, 191

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Sept (Day) 30, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Sept 30 1917, that I saw h— alive on Sept 29 1917, and that death occurred, on the date stated above, at 12.01 m.

The CAUSE OF DEATH* was as follows:

Lamp seal Diphtheria

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. 1 ds.

(Signed) W. K. Burtle M. D.

Sept 30, 1917. (Address) 2042 Hudson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Patrick's County — DATE OF BURIAL, Oct 1 1917

20-UNDERTAKER John A. Mann — ADDRESS 300 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8890

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1120 Riverside Ave. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Garland.

(Residence in Baltimore: No. 1120 Riverside Ave. St.:)

52 yrs. 3 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, June 17th. 1865., 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. 3 mos. 10 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship joiner.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Garland.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary Kane.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Garland, (nephew.)
(Address) 1110 Riverside Ave.

15-
Filed ....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Reinhardt (Coroner.) M. D.

Sept, 28, 1917 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Peters Cem	Oct. 1, 1917.
20-UNDERTAKER M. L. Flynn	ADDRESS 1452 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 8891

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 S. Ellwood Ave ST.; 155 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Nelka

(Residence in Baltimore: No. 1210 S. Ellwood Ave St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, October 13th (Month) (Day), 1912 (Year)

7-AGE, 4 yrs. 11 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Nelka

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Stanislava Popolski

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nelka

(Address) 1210 S. Ellwood Ave

15-

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 29th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 5 191..., to Sept 28 191..., that I saw h[illegible] alive on Sept 28 191..., and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 2, 1917, (Address) 1818 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Stanislaus Cem.	Oct. 1st, 1917.
20-UNDERTAKER	**ADDRESS**
Stanislaus J. Fiatkowski	1518 S. Ellwood

OCT 1 1917

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8892

CERTIFICATE OF DEATH.

104 D 8892

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Binney ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredrick Young

(Residence in Baltimore: No. 916 Binney St.; — yrs., 5 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 1, 1917 (Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... infant

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jas. H. Harrington

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Lillie E Young

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie E. Young

(Address) 916 Binney St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 28 1917, and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Exhaustion from Enteritis

Colitis..... (Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) (Bronchitis)

Marasmus..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Sept 1, 1917. (Address) 504 S Donnell St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Oct. 1st, 1917.

20-UNDERTAKER Stephen J. Fralkowski — ADDRESS 1098 Kenwood Ave

N.B. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8893

CERTIFICATE OF DEATH.

119

D 8893

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Gold ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pamilee Morris

(Residence in Baltimore: No. 707 Gold St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, October 4 (Month), (Day), 1878 (Year)

7-AGE, 38 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private family

9-BIRTHPLACE, (State or Country), Baltimore Co Randallstown

PARENTS.

10-NAME OF FATHER, Alexander Canfield

11-BIRTHPLACE OF FATHER (State or Country) Randallstown

12-MAIDEN NAME OF MOTHER Louise Worfield

13-BIRTHPLACE OF MOTHER (State or Country), Randallstown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Morris

(Address) 707 Gold st

15-

OCT 1. 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29 (Month), (Day); 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 191 7, to Sept 29 191 7, that I saw h er alive on Sept 29 191 7, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Gastro Enteritis

..... (Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

..... (Duration) yrs. mos. 15 ds.

(Signed) Wm H Morris M. D.

Sept 29, 191 7 (Address) 120 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Thomas Randallstown — DATE OF BURIAL, Oct 4, 191 7.

20-UNDERTAKER F C H Holland — ADDRESS 1631 D Ave

N. B.—Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8894 — 79 — D 8894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1647 N Fulton Ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria May Stemmer Michael

(Residence in Baltimore: No. 1647 N Fulton Ave St.; 2 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, June (Month) 12 (Day), 1858 (Year)

7-AGE, 59 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Daniel Barnick

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Lucy Berry

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harriet Kreutz

(Address) 1647 N Fulton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1917, to Sept 30 1917, that I saw h[er] alive on Sept 30 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
(Mitral Stenosis)

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (Duration) — yrs. — mos. — ds.

(Signed) [illegible] M. D.

Oct 1 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dunmont Md — DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Wm. Cook — ADDRESS 502 E. Mon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8895

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1228 E. Federal St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie D. Jones

(Residence in Baltimore: No. 1228 E. Federal St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Married

6-DATE OF BIRTH: June 14 1866 (Month) (Day) (Year)

7-AGE: 51 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: August York

11-BIRTHPLACE OF FATHER (State or Country): Mass.

12-MAIDEN NAME OF MOTHER: Kerryleen Mathews

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur D. Jones

(Address) 1228 E. Federal St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept. 29th, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept. 13th, 1917, to Sept. 29th, 1917, that I saw h[er] alive on Sept. 28th, 1917, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Heart complication

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paraplegia

(Duration) 2 yrs. mos. ds.

Signed) Wm. A. Meyer M. D.

Sept. 29th, 1917 (Address) 1011 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: Oct. 1, 1917

20-UNDERTAKER: Wm. Cook

ADDRESS: 302 S. Matt

N.B. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 8896

HEALTH DEPARTMENT—CITY OF BALTIMORE

1725 8896

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: W WARD)

2-FULL NAME Mary A. Hartman Wheat

(Residence in Baltimore: No. 106 N. Fremont St.; yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Don't Know, ... (Month) ..... (Day) 1 (Year)

7-AGE. 44 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of Industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Robert Mason

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter R. Wheat

(Address) 106 N. Fremont ave

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 29, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull (Base) accident by falling down stairs at her home

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Epilepsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Reuben M. D. (Coroner.)

Sept 30, 191.7 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 106 N Fremont Ave

Former or usual residence 106 N Fremont ave

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Oct. 3, 19..
20-UNDERTAKER	ADDRESS
William Cook	707 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8897.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8897.

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6347 N Belnord Ave St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E Boser

(Residence in Baltimore: No. 6347 N Belnord Ave St.; Life yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Jan 27 ....., 187.. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
46 yrs. 8 mos. 2 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 0 .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Bysse

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Donovan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Boser

(Address) 6347 N. Belnord Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29/17, 191... (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 191 7, to Sept 29 191 7, that I saw her alive on Sept 28 191 7, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Weyler M. D.

9/30, 191 7. (Address) 1128 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Patricks Cemetery	Oct. 2/17 191...
20-UNDERTAKER	**ADDRESS**
Christian Miller	2334 E Jefferson St

Spec.—8-24-14—M. & T.—2000 Bks.

D 8893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8893

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Holsyn

(Residence in Baltimore: No. 421 W. 23rd St ST.; — yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Mar (Month) 8 (Day), 1874 (Year)

7-AGE. 43 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Henrietta

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp.

(Address) Calvert St.

15-

Filed....., 191.....

Registrar

OCT 1 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Sept 29 1917, that I saw h[er] alive on Sept 29 1917, and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Stroke (Duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Edward F. Smith M. D.

Sept. 29, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 19 ds. In the State 25 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 421 W. 23rd St.

Former or usual residence 421 W. 23rd St.

19-PLACE OF BURIAL OR REMOVAL, Edmondson Cemetery DATE OF BURIAL, 10/3/17

20-UNDERTAKER, C. H. Fitzpatrick ADDRESS 2433 N. Howard Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8899

CERTIFICATE OF DEATH.

D 8899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N Centralo't St.; 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A Candley

(Residence in Baltimore: No. 419 N Central ave St.: ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, Nov 5 (Month), (Day), 1874 (Year)

7-AGE, 43 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Joseph Wingle

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lydia Bowers

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Standley

(Address) 419 N Central ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28 (Month), (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 28 1917, that I saw her alive on Sept 27 1917, and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 5 ds.

(Signed) Adolf E. Eisenlaug M. D.

Sept 29, 1917. (Address) 2201 E. 3 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bluri Cemitary	Oct 2, 1917
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	506 East 24

Spec.—8-24-14—M. & T.—2000 Bks.

D 8900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8900

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Portugal ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Omila Newcomb

(Residence in Baltimore: No. 2216 Portugal St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Infant

6-DATE OF BIRTH, August 14, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Newcomb

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Regina Mengel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Newcomb

(Address) 2216 Portugal

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24" 1917, to Oct 1" 1917, that I saw h[er] alive on Oct 1" 1917, and that death occurred, on the date stated above, at 12[10] [A]. m.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Theogene Hodgdon M. D.

Oct 2" 1917 (Address) 2179 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart	Oct 1, 1917
20-UNDERTAKER	**ADDRESS**
Wendell Wyffel & Son	378 N

OCT 1 1917 REGISTRAR OF VITAL STATISTICS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8901

CERTIFICATE OF DEATH.

104 D 8901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Fleet ST.; 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M Price

(Residence in Baltimore: No. 2321 Fleet St.; yrs. 10 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, Nov. (Month) 16 (Day), 1916 (Year)

7-AGE,	If LESS than 1 day,
yrs. 10 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Joseph Price

11-BIRTHPLACE OF FATHER (State or Country), Balt

12-MAIDEN NAME OF MOTHER Kate Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Price

(Address) 2321 Fleet

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Sept 30 1917, that I saw h[illegible] alive on Sept 29 1917, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Meo-Colitis

(Duration) ....yrs. ....mos. 21 ds.

(Signed) Alma B Leonard M. D.

Sept 30, 1917 (Address) 718 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct..., 191.7
20-UNDERTAKER	ADDRESS
Wendell Ruffell & Son	37 S Amer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 8902

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S Duncan ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George B. Lang

(Residence in Baltimore: No. 216 S Duncan St.; ..... yrs., 2 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, ... July (Month) 18 (Day), 1914 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 2 mos. 11 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Lang

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Seipel

13-BIRTHPLACE OF MOTHER (State or Country), Washington, D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Lang

(Address) 216 S. Duncan St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 29 1917, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
Inanition

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph L. Walmsley M. D.

Sept 30 1917, (Address) 216 S Duncan St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	October 1 1917
20-UNDERTAKER	ADDRESS
Wendell Diffel's Son	37 S Howard St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 8903

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2143 Cambridge ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Dobry

(Residence in Baltimore: No. 2143 Cambridge St.: 1 yrs., 5 mos. 24 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, April 6, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Dobry

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Helen Klinesmith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Dobry

(Address) 2143 Cambridge St.

15-

Filed OCT 1 1917, 191.... HARRY D. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 191 , to Sept 30 1917 , that I saw h(er) alive on Sept 30 1917 , and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonia.

Primary (Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Tuberculosis (Duration) yrs. mos. ds.

(Signed) Jno. B. Burns M. D.

Oct 1, 191... (Address) 2818 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	Oct 2 1917

20-UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann

Spec.—8-24-14—M. & L.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8904

CERTIFICATE OF DEATH.

28 ✓ D 8904

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1760 E North Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia D Hoerr

(Residence in Baltimore: No. 1760 E North Ave St.) 8 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 1, 1885 (Month) (Day) (Year)

7-AGE, 32 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country) Pat Depaut Md

PARENTS.

10-NAME OF FATHER, Robert H Tigner

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Dixon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry A Hoerr

(Address) 1760 E North Ave.

15-

OCT 1. 1917 HARRY O. ANDREWS

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30th, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from August 25th 1917, to September 30th 1917, that I saw h Her alive on September 30th 1917, and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary).....

..... (Duration) yrs. mos. ds.

(Signed) Charles A. Wright M. D.

October 1st, 1917, (Address) 103 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemt — DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER William Cook — ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8905

CERTIFICATE OF DEATH.

105 D 8905

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Richardson St.; 24 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francisca Bender

(Residence in Baltimore: No. 1420 Richardson St.; V yrs., mos. V ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 9 (Month) 28 (Day), 1915 (Year)

7-AGE 2 yrs. mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... N.D.

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Laurence Bender

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Melnitz

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Bender

(Address) 1420 Richardson

15-

Filed OCT 1 1917, 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9, 20 1917, to 9, 30 1917, that I saw her alive on 9, 30 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic [illegible] Enteritis

(Duration) 3 Weeks

CONTRIBUTORY (Secondary) Generalized from Birth

(Duration) 2 yrs. mos. ds.

(Signed) [illegible] M. D.

10/1/17 (Address) 1428 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Hannis Town

DATE OF BURIAL, Oct 2 1917

20-UNDERTAKER William Frankowski

ADDRESS 1618 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8906

CERTIFICATE OF DEATH.

47 D 8906

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 Penrose Ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo A Fitzsimmons

(Residence in Baltimore: No. 2132 Penrose Ave St.; 19 yrs., 7 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the Word.)
Male	White	Single

6-DATE OF BIRTH, Jan 31, 1898 (Month) (Day) (Year)

7-AGE, 19 yrs. 7 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Naval
(b) General nature of industry, business, or establishment in which employed (or employer): Milit[illegible]

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James J. Fitzsimmons

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Bridget Faherty

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J. Fitzsimmons

(Address) 2132 Penrose Ave

15-

Filed ....., 191.....

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 30 1917, that I saw h[illegible] alive on Sept 29 1917, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Acute Rheumatic fever
(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Ac. Dilatation of Heart.
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) E. C. Carolan M. D.
9/30/17 (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 3, 191[illegible]

20-UNDERTAKER Jos B Cook — ADDRESS 1003 W Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8907

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1226 Division St.; 17 WARD)

REGISTERED No. C 8907

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. F. Cook

(Residence in Baltimore: No. 1226 Division St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	Col'd	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 18.... (Year)

7-AGE, 69 Years ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 606

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John S. Cook

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Eliza Cook

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calvin Robson

(Address) 1743 Madison Ave

15-

Filed ....., 191.... Registrar.

OCT 1, 1917 ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis 1 yr.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn Cemetery	Oct. 3 ....., 19....

20-UNDERTAKER	ADDRESS
John H. Todd	412 Mulberry St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8908 — 64 D 8908

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Fulford St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel L Baldwin

(Residence in Baltimore: No. 2619 Guilford Ave. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 26, 1864 (Month) (Day) (Year)

7-AGE, 52 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer): 063

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Caleb Baldwin

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Martha Miller

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S. Baldwin

(Address) 2619 Guilford

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 30 1917, to Sep 30 1917, that I saw h m alive on Sep 30 1917, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 8 1/2 hours

CONTRIBUTORY (Secondary) High blood pressure

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Wm S Watson M. D.

Oct 1, 191.. (Address) 712 S St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Oct 2, 191...
20-UNDERTAKER	ADDRESS
H. Fletcher & Co	Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Watson 712 St Paul 22 ct

Spec.—8-24-14—M. & T.—2000 Bks.

D 8909

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D 8909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2502 Wilkens ave WARD 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent A. Sullivan

(Residence in Baltimore: No. 2502 Wilkens ave St.; 15 yrs., 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) single

6-DATE OF BIRTH, Nov. 6, 1901 (Month) (Day) (Year)

7-AGE, 15 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Patrick L Sullivan

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Catherine Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sullivan

(Address) 2502 Wilkens Ave

15-

Filed....., 191.....

Registrar.

OCT 1, 1912 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Sept 29 1917, that I saw h in alive on Sept 29 1917, and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis (acute)

.....

.....

..... (Duration) ....yrs. ....mos. 8 ....ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

..... (Duration) ....yrs. ....mos. 8 ....ds.

(Signed) Sidney H. Streett M. D.

Sept 30 1917 (Address) 1431 E Fort Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va

DATE OF BURIAL, Sept 2 1917

20-UNDERTAKER, M. A. Flynn

ADDRESS 1422 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8910

CERTIFICATE OF DEATH.

55 D 8910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Franklin & Green Hosp St.; 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Montour

(Residence in Baltimore: No. 636 W. Lee st St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Single

6-DATE OF BIRTH, June 20, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): ?

9-BIRTHPLACE, (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, Edward W. Montague

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Anna Winston

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Montour

(Address) 636 W. Lee St.

15-

Filed....., 191.....

Registrar.

OCT 1 1917 ROBERT R. KRAETER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Sept 30 1917, that I saw her alive on Sept 30 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage

?

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) ?

(Duration) ...yrs. ? mos. ...ds.

(Signed) Mary Porterfield M. D.

Sept 30, 1917. (Address) Franklin & Green Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 2 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 636 W. Lee st

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Oct 2nd 1917

20-UNDERTAKER, F. A. Forwarse — ADDRESS 703 Monroe

Spec.—8-24-14—M. & T.—2000 Bks.

D 8911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8911

Letitia

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 N Calvert ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Letitia McKean Buchanan

(Residence in Baltimore: No. 1724 N Calvert St.; 6 yrs.. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	White	Single

6-DATE OF BIRTH. February 27, 1837 (Month) (Day) (Year)

7-AGE. 80 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Annapolis, Maryland

PARENTS.

10-NAME OF FATHER. Franklin Buchanan

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Ann Catharine Lloyd

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. McKean Buchanan

(Address) 1724 N Calvert St.

15-

Filed....., 191.....

Registrar.

OCT 1 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1916, to Sept 30 1917, that I saw h[illegible] alive on Sept 30 1917, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Arterio Sclerosis (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) [illegible] M. D.

Oct 1, 1917. (Address) 100 S Catherine St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Wye Talbot County Md DATE OF BURIAL. Oct 1st, 1917

20-UNDERTAKER Henry W. Jenkins & Co ADDRESS Orchard & Eutaw

Luisa M Patrella

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8912 ✓ D 8912

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 902 Fawn St. WARD) 3

2-FULL NAME Luisa M Patrella

(Residence in Baltimore: No. 902 Fawn St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	wh	single

6-DATE OF BIRTH, Sept. (Month) 12., (Day) 1917 (Year)

7-AGE, ...yrs. ....mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Patrella

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Elizabeth Bernozzo

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Patrella

(Address) 902 Fawn

15-

Filed ....., 191.... Registrar.

OCT 1 1917 ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature birth (7 mos.

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Leslie Guy M. D.
(Coroner.)

10/1, 191.7 (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent	Oct. 2, 1917
20-UNDERTAKER	ADDRESS
Wendell Dysell & Son	37 S Howard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Novak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8913

CERTIFICATE OF DEATH.

39 D 8913

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7844 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Schimunek

(Residence in Baltimore: No. 7844 Hudson St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) ..... (Day), 1844 (Year)

7-AGE, 69 yrs. 9 mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker.
(b) General nature of industry, business, or establishment in which employed (or employer): 003

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Schimunek.

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Chvatal

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Schimunek

(Address) 7844 Hudson St.

15-

OCT 1, 1917 ROBERT E. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 29th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 15 1917, to Sept 29 1917, that I saw h.. alive on Sept 29 1917, and that death occurred, on the date stated above, at 5.40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tonsil (Left)

..... (Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) Emil Novak M. D.

Oct. 1, 191.7 (Address) 267 Portland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem.

DATE OF BURIAL, Oct. 2, 191.7

20-UNDERTAKER Lilly & Zeiler.

ADDRESS 403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Robertson.

D 8914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

39 D 8914

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2530 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Fehn

(Residence in Baltimore: No. 2530 Orleans St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... Jan. (Month) 19th (Day), 1872 (Year)

7-AGE, ... 45 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Nicholas Fehn

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Margaret Wehner

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Fehn

(Address) 2530 Orleans St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 30th (Day), 1917. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20" 1917, to Sept 30th 1917, that I saw h.. alive on Sept 29" 1917, and that death occurred, on the date stated above, at 12" A.m.

The CAUSE OF DEATH* was as follows:

a.....

Carcinoma of tongue

..... (Duration) 2 yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Leopold Kaestner M. D.

Oct 1" 1917. (Address) 2139 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct. 3rd, 1917.

20-UNDERTAKER Lilly and Sons ADDRESS 403 S. Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 8915

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Richardson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Marcus~~ Frosta Levaskevich.

(Residence in Baltimore: No. 1435 Richardson St.; yrs., 4 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, May (Month) 1st (Day), 1912 (Year)

7-AGE, ... yrs. 5 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltic. Md.

PARENTS.

10-NAME OF FATHER, Sergius Levaskevich

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER, Philippa Hakelon

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Brook

(Address) 1507 Fortieth

15-

OCT 1, 1917 ROBERT B. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) — 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9—8— 1917, to 10—1— 1917, that I saw her alive on 9—30— 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Brook M. D.

10—1—, 191.7 (Address) 1507 Fortieth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 1st Evangelical — DATE OF BURIAL, Oct 2, 1917

20-UNDERTAKER Wm. Fialkowski — ADDRESS 1618 Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8916

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 ✓ D 8916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 Maple Ave ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gyndolin Williams

(Residence in Baltimore: No. 3603 Maple Ave St.; ....yrs., 4 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH. June 1, 1913 (Month) (Day) (Year)

7-AGE. ....yrs. 4 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), City Balto

PARENTS.

10-NAME OF FATHER. Clark Williams

11-BIRTHPLACE OF FATHER (State or Country), City Balto.

12-MAIDEN NAME OF MOTHER Catherine Guerin

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Brown

(Address) 3603 Maple Ave.

15-

Filed....., 191.... Registrar.

OCT 2- 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 1st, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 1 1917, that I saw h[illegible] alive on Oct 1 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration)....yrs....mos. 27 ds.

CONTRIBUTORY (Secondary)....

(Duration)....yrs....mos....ds.

(Signed) Chas. C. Kleinert M. D.

Oct 1, 1917 (Address) 1412 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL. St Mary's Hampden

DATE OF BURIAL. 10/3, 1917.

20-UNDERTAKER Ellenworth & Son

ADDRESS 3617 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8917

138 D 8917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 W. Fayette ST.: 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Atkinson

(Residence in Baltimore: No. 915 W. Fayette St.: 44 yrs., ~ mos., ~ ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 5 (Day), 1872 (Year)

7-AGE, 44 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Co Md.

PARENTS.

10-NAME OF FATHER, Charles Eaton

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter E. Atkinson

(Address) 915 W. Fayette St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 1st 1917, that I saw her alive on Oct 1st 1917, and that death occurred, on the date stated above, at 10-40 a.m.

The CAUSE OF DEATH* was as follows:

1. Puerperal Post Partum Eclampsia
17 hours after Parturition

(Duration) 17 hrs. hours ds.

CONTRIBUTORY (Secondary) none

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) Maury Co Phys M. D.

Oct 1, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 3rd, 191.

20-UNDERTAKER Geo J Smith

ADDRESS 1000 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 8918 · HEALTH DEPARTMENT—CITY OF BALTIMORE · ✓D 8918

CERTIFICATE OF DEATH.

X 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary ST.; 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Godfrey Seiler

(Residence in Baltimore: No. 4303 Groveland Ave St.; ~ yrs. ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Jan (Month) 18 (Day), 1870 (Year)

7-AGE, 47 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Godfrey Seiler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Turner

(Address) 4303 Groveland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Sept 30 1917, that I saw him alive on Sept 30 1917, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Nephritis

Oedema of lungs

(Duration) yrs. 3 mos. P ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(Duration) yrs. 2 mos. ds.

(Signed) H. H. Hamman M. D.

Sept 30, 1917. (Address) Church Home Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 15 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4303 Groveland Ave.

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Geo J. Smith — ADDRESS 1000 Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8919

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 Mulliken ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta D. Harris

(Residence in Baltimore: No. 1221 Mulliken St.; 43 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Oct. (Month) 2 (Day), 1873 (Year)

7-AGE, 43 yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Harris

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Hudson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Harris

(Address) 1221 Mulliken St

15-

Filed....., 191.....

Registrar.

N.B.—Every item of information should be given if possible, so that it may be important. See instructions on back of certificate.

CAUSE OF DEATH in plain

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 27 1917, and that death occurred, on the date stated above, at 1.05 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Isaac M. D.

Oct 1, 191.7. (Address) 17 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [illegible] Cemetery

DATE OF BURIAL, Oct. 3, 1917

20-UNDERTAKER Chas. H. Johnson

ADDRESS 446 N Carey

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8920

28 ✓

D 8920

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1345 Ward St ST. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elmer Finney

(Residence in Baltimore: No. 1345 Ward St St.; — yrs. — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Unknown, 1899 (Month) (Day) (Year)

7 AGE: 15 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: George Finney

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Maggie V Williams

13 BIRTHPLACE OF MOTHER (State or country): Md

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie Blake

(Address) 1345 Ward St

15 Filed ..... 191 .....

OCT 2- 1917

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 29 (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Sept 29 1917, that I saw h— alive on — 29, 1917 and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ... yrs. 7 mos. ... ds

Contributory (SECONDARY) Exhaustion

(Duration) ... yrs. 3 mos. ... ds.

(Signed) [illegible] M. D.

Oct 2, 1917 (Address) 147 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 2, 1917

20 UNDERTAKER: Hamel Eccard — ADDRESS 916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8921

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 E Lombard ST.; 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary K. Hartman

(Residence in Baltimore: No. 1625 E Lombard St.; 46 yrs., 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 9 (Day), 1871 (Year)

7-AGE, 46 yrs. 3 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Louis Kohlman

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Katherine Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Chas. H. E. Hartman

(Address) 1625 E. Lombard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 191., to Sept 30 191., that I saw h.. alive on Sept 30 191., and that death occurred, on the date stated above, at .. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) L. Z. Tuttle M. D.

Oct 1, 191.. (Address) 2012 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Peter Nicolaus

ADDRESS 204 Eastern

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Data important. See instructions on back of certificate.

OCT 2 1917

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8922 ✓ 79 D 8922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1221 W. Cross ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Miller

(Residence in Baltimore: No. 1221 W. Cross St. 30 yrs., — mos.— ds.)

N. B.—Every item of information should be given, so that it may be properly classified. Blanks must not be left. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~married~~, ~~widowed~~, or ~~divorced~~, (Write the word.) single

6-DATE OF BIRTH, March 25, 1855 (Month) (Day) (Year)

7-AGE, 62 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, F. Robt. Miller

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary O'Connor

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Haynes

(Address) 1221 W. Cross St.

15-

Filed OCT 2 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1917, to Sept. 30 1917, that I saw him alive on Sept. 28 1917, and that death occurred, on the date stated above, at 10 10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) yrs. mos. 7 ds.

(Signed) J. C. Lunsford Kirn M. D.

Oct 2, 1917. (Address) 818 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Oct 2nd, 1917.

20-UNDERTAKER John J. Fields

ADDRESS 1200 N Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

D 8923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8923

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary St. Hager

(Residence in Baltimore: No. 311 S. Madeira St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, March 24, 1880 (Month) (Day) (Year)

7-AGE, 37 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss L. Daisy Blake

(Address) Federated Charities

15-

Filed, OCT 2 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1917, to Oct. 1 1917, that I saw h[illegible] alive on Sept. 30 1917, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) — yrs. — mos. — ds.

(Signed) Chas. S. Bull M. D.

10/2/17, 191... (Address) Harrisburg Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Evangelical DATE OF BURIAL, Oct 2, 1917.

20-UNDERTAKER H. Sanders Sons ADDRESS 1710 Pratt St

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each answer important. See instructions on back of certificate.

D 8921 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 8921

CERTIFICATE OF DEATH.

157

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1006 N C Monough St. WARD)

2-FULL NAME Herman D Millendorf

(Residence in Baltimore: No. 1006 N C Monough St. Yrs. Lifted mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mat

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 14, 1842
(Month) (Day) (Year)

7-AGE, 74 yrs. 7 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Home) 050

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Wm Millendorf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bumgardner

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Millendorf

(Address) 1006 N C Monough St

15-

Filed OCT 2- 1917, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
apoplexy
bed ridden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J R Guy Jr M. D.
(Coroner)

191... (Address) 11 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Oak Lawn — DATE OF BURIAL, Oct 2, 1917

20-UNDERTAKER Robt T Turner — ADDRESS 1428 N Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15

D 8925

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 E Lafayette St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. & Rebecca Bushey

(Residence in Baltimore: No. 2032 E Lafayette St.: Life yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov 6, 1916 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 10 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Arthur C. Bushey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Alberta King

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur C. Bushey

(Address) 2032 E. Lafayette St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 1916, to Sept 30th 1917, that I saw h[illegible] alive on Sept 29th 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Convulsions from duration of 24 hrs.

Epilepsy Birth (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) I. D. Bushard M. D.

Oct 1, 1917. (Address) 711 W Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Oct 2, 1917.

20-UNDERTAKER Robt J Turner ADDRESS 1422 N Broadway

N. B.—Every item of information should be properly entered. Remember that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8926

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Bond ST.; 2 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Wilson

(Residence in Baltimore: No. 715 S. Bond st St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Aug. (Month) ..... 20 (Day) ....., 1837. (Year)

7-AGE, ... 80 yrs. ..... 1 mos. ..... 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Georgianna Warrington

(Address) 214 N. Milton ave.

15-

OCT 2- 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Septem 30th (Month) ..... (Day) ....., 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Sept 30 1917, that I saw her alive on Sept 30 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

1 Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Hatchell M. D.

Sept 30 191.7 (Address) 1922 Eutaw st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Carmel Cem	Oct. 3, 1917.
20-UNDERTAKER	**ADDRESS**
Wm. C. Blask	927 N. Broadway

N. B.—Every item of information called for in this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 8927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8927

CERTIFICATE OF DEATH.

50

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2634 Maryland av ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward M Kesler

(Residence in Baltimore: No. 2634 Maryland av St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	M

6-DATE OF BIRTH, July (Month) 10 (Day), 1868 (Year)

7-AGE, 53 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Kesler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Charlott Wade

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Myra Kesler

(Address) 2634 Maryland ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 29 1917, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Chronic
Interstitial Nephritis
Uremia

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Old age

(Duration) — yrs. — mos. 6 ds.

(Signed) C. H. McClenahan M. D.

Oct 1, 1917 (Address) 1412 Linden av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudan Park Cem—	Oct 2, 1917
20-UNDERTAKER	ADDRESS
McClean & Jones	822 Lindan ave

N. B.—Every item of information must be properly answered, so that it may be properly classified. Especially important is the CAUSE OF DEATH in plain terms, so that it may be properly classified. Especially important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8928

CERTIFICATE OF DEATH.

80 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Oakley ST.; 16 WARD)

REGISTERED NO. C 8928

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Metzner

(Residence in Baltimore: No. 2003 Oakley St.; 67 yrs., 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct (Month) 16 (Day), 1849 (Year)

7-AGE, 67 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Metzner

(Address) 2023 W. Lanvale

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1917, to Sept 30th 1917, that I saw her alive on Sept 29th 1917, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Endocarditis

(Duration) 2yrs 1 mos. ds.

(Signed) Gilbert V. Metzner M. D.

Sept 30, 1917 (Address) 530 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death? ✓ ✓ ✓

Former or usual residence ✓ ✓ ✓

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Stewart & Woods Co

ADDRESS 108 N. North

N. B.—Every item of information must be given, so that it may be properly classified. Especially important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8929 D 8929

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH Women Hospital

CITY OF BALTIMORE: (No. Lafayette & Johnson ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Alberta Griffith Burt

(Residence in Baltimore: No. Norfolk Va (6 yrs) St.; (Balto. 46 years) yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~STATUS~~, MARRIED, ~~WIDOWED, OR DIVORCED.~~ (~~Write the word~~)
Female	White	Married

6-DATE OF BIRTH, November (Month) 6 (Day) 1865 (Year)

7-AGE, 51 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Romulus B. Griffith

11-BIRTHPLACE OF FATHER (State or Country), Mary Land

12-MAIDEN NAME OF MOTHER Alberta Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Mary Land

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). W. P. Turner (Brother-in-law)

(Address). Park Circle Apts. Balto.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1917, to Oct 1 1917, that I saw her alive on Sept 30 1917, and that death occurred, on the date stated above, at 5.30 pm.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. ds.

(Signed) Hattie M. Clark M. D.

Oct. 1, 1917. (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. 25 ds. In the State ....yrs. ....mos. 25 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Belvedere apts. Norfolk Va.

19-PLACE OF BURIAL OR REMOVAL Green Mount Cy DATE OF BURIAL Oct 2, 1917

20-UNDERTAKER Stewart & Mowen & Co ADDRESS 108 W North Ave

N. B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D 8930

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 W Biddle ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lindley Leitner

(Residence in Baltimore: No. 752 W Biddle St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... 1867 ....., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Hardware

504 074

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Leitner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Hannah Bitty

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE ~~IS~~ TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Rosa Leitner

(Address) ..... 752 W Biddle St

15-

Filed ....., 191.....
Registrar.

N. B.—Every item of information should be given as fully as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 29 th, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27 191 7, to Sept 29th 191 7, that I saw h alive on Sept. 29 191 7, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia Lobar
.....
.....
..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct. 1, 191 7 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct. 2, 191 7

20-UNDERTAKER Hilbert Brown ADDRESS 164 N. Schroeder

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8931 | 179 | D 8931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2115 Hollins ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gerhard Jr

(Residence in Baltimore: No. 2115 Hollins St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH: January (Month) 10 (Day), 1885 (Year)

7-AGE: 32 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None (Invalid)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Gerhard

11-BIRTHPLACE OF FATHER (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Florence Carruthers

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Florence Gerhard

(Address) 2115 Hollins St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 191....., and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) Walter A Eck M. D.

10-2.., 1917 (Address) 545 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 2, 1917

20-UNDERTAKER: Leo A Gerber — ADDRESS: Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8932

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Otterbein

(Residence in Baltimore: No. Univ Hospt St.; 4 yrs., — mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the Word.)
Male	White	Single

6-DATE OF BIRTH, Unknown (Month) (Day) 1907 (Year)

7-AGE, 10 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Boy
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Otterbein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER A Schessman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Wm Otterbein

(Address) Morrell Park

15-

Filed OCT 2 1917; 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1917, to Sept 30 1917, that I saw him alive on Sept 30 1917, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows: Tuberculosis of Meninges

(Duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C B Brumbaugh M. D.

Sept 30 1917. (Address) Univ Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 30 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Morrell Park Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct 3, 1917
20-UNDERTAKER	ADDRESS
Geo A Gerber	Balto Hayward 54

N.B. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8933

CERTIFICATE OF DEATH.

78 D 8933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Hull St. St.; 24 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Barnett

(Residence in Baltimore: No. 1422 Hull St. St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, June (Month) 21 (Day), 1896 (Year)

7-AGE, 21 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)..... 069

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, J. W. Barnett

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Novella Dix

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lloyd Barnett

(Address) Washington D.C.

15-

Filed OCT 2 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10th (Month) 1st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1917, to Oct. 1 1917, that I saw her alive on Oct. 1 1917, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 7 ds.

(Signed) Maurice Gore M.D.

Oct 2 1917 (Address) 423 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Irvington Va

DATE OF BURIAL, Oct. 2, 1917

20-UNDERTAKER M. D. Flynn

ADDRESS 1432 Light St.

N. B.—Every item in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8934

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 8934

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Gwynn Oak Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eric Arnold Forbes Jr

(Residence in Baltimore: No. Chas & Belvidere Parkway St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 27, 1917 (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 12 hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas H Forbes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Zola M Hamm

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zola M Forbes

(Address) 2022 Gwynn Oak Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Sept 28 1917, that I saw h er alive on Sept 27 1917, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Stomach

Pneumonia Both Eight Months,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R B Arnold M. D.

9.30., 1917. (Address) 2147 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Johns Hopkins Hospital — DATE OF BURIAL, Oct 1 1917

20-UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Dec. Wm. E. Wickham Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8935

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Kelly

(Residence in Baltimore: No. St. Elizabeths Home St.: 5 yrs., 5 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	negro	

6-DATE OF BIRTH, April (Month) 2 (Day), 1912 (Year)

7-AGE, 5 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Anthon Kelly

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 15 1917, to Sept 29 1917, that I saw h[illegible] alive on Sept 29 1917, and that death occurred, on the date stated above, at 10A. m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Enteritis

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

Oct 2, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
	....., 191...
20-UNDERTAKER	ADDRESS

OCT 3 1917 JOHNS HOPKINS HOSPITAL OCT 1 1917

Commissioner of Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8936

CERTIFICATE OF DEATH.

REGISTERED NO. C 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Virginia Ave. ST.; H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Boy Fallon

(Residence in Baltimore: No. 7 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W	—

6-DATE OF BIRTH, 9 (Month) 5 (Day), 1917 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 10 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER James Fallon

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary Simmons

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed OCT 2 1917, 191... HARRY O. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-5 1917, to 9-5 1917, that I saw him alive on 9-5 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

b Pneumonia

c .....

d ..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. McCrae M. D.

9-7, 1917. (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT. 1 1917
20-UNDERTAKER Commissioner Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Every item important. See instructions on back of certificate.

5192

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8937

CERTIFICATE OF DEATH.

129 D 8937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N. Eden St.; 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maryland Lippscomb

(Residence in Baltimore: No. 529 N. Eden St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Bolden

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston Lippscomb

(Address) 529 N Eden St

15-

Filed ....., 191.....

Registrar.

N. B. Fill out CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Sept 29 1917, that I saw her alive on Sept 28 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows: Debility following laparotomy and Pneumonia

Duration ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

Duration ..... yrs. ..... mos. one ds.

(Signed) Dr Wm Field Dorsey M. D.

Sept 29, 1917. (Address) 822 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery DATE OF BURIAL, Oct ..., 1917

20-UNDERTAKER R E Ernst ADDRESS 1405 W Eden

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8938

CERTIFICATE OF DEATH.

54 D 8938

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 E. Chase ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Guenther

(Residence in Baltimore: No. 1232 E Chase St.; 22 yrs., 1 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July 31, 1895 (Month) (Day) (Year)

7-AGE, 22 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dress maker
(b) General nature of industry, business, or establishment in which employed (or employer): 069

22

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Guenther

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Magdelena Memminger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. John Guenther

(Address) 1232 E. Chase St

15-

Filed ..... 191.....

Registrar.

CAUSE OF DEATH in plain terms. Be sure to answer all questions important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1917, to Sept 30 1917, that I saw her alive on Sept 30 1917, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... mos. ..... ds.

(Signed) John D. Heck M. D.

Oct 1, 1917. (Address) 1366 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	Oct 3rd, 1917
20-UNDERTAKER Henry Horck Son	ADDRESS 1301 E Eager St

OCT 2 - 1917

Spec.—6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8939

CERTIFICATE OF DEATH.

40 D 8939

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1029 N. Somerset St.; 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christopher Sebald

(Residence in Baltimore: No. 1029 Somerset St.: 46 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. 10, 1841
(Month) (Day) (Year)

7-AGE, 75 yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. John Sebald

(Address) 1029 Somerset St

15-

Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms, so that it can be understood. Fill out all items. Be particular and exact. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1st, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1917, to Sept. 30, 1917, that I saw him alive on Sept. 30, 1917, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Metastasis)

..... (Duration) one yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

..... (Duration) one yrs. ..... mos. ..... ds.

(Signed) C. J. Sebald M. D.

Oct. 1st, 1917. (Address) 1001 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	Oct. 3rd, 1917
20-UNDERTAKER	**ADDRESS**
Henry Hock & Son	1301 E. Eager St

D 8940

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8940

1 PLACE OF DEATH

REGISTERED No. C 64

CITY OF BALTIMORE (No. 1122 McCulloh ST. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Konig

(Residence in Baltimore: No. 1122 McCulloh St.; 50 yrs. 6 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6 DATE OF BIRTH March 17, 1862 (Month) (Day) (Year)

7 AGE 55 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm. Kearney

11 BIRTHPLACE OF FATHER (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Don't Know.

13 BIRTHPLACE OF MOTHER (State or country): Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. J. Kearney,

(Address) 1911 E. Fayette St.

15. Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1917, to Sept 30, 1917, that I saw her alive on Sept. 30, 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

- Paralysis -

(Duration) — yrs. — mos. 1 ds

Contributory (SECONDARY) Z

(Duration) yrs. mos. ds.

(Signed) Tom M. Sappenbaker M. D.

1917 (Address) 709 Madison ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	10-3rd, 1917
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son Co	1116 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If not known, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 2- 1917

Spec.—8-24-14—M. & T.—2000 Blks.

D 8911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 8911

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mat Lakola

(Residence in Baltimore: No. 1820 Fairmount Av St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day), 1852 (Year)

7-AGE. 65 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 5 000
(b) General nature of industry, business, or establishment in which employed (or employer) None. 000

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levis

(Address) 1411 E Balto St

15-

Filed ....., 191.... ROBERT E. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 2, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct 2 1917, that I saw him alive on Oct 2 1917, and that death occurred, on the date stated above, at 2.54 p.m.

The CAUSE OF DEATH* was as follows:

Atypic Endocarditis

Renal Colic

(Duration) Unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Embolism 1 min

(Duration) ... yrs. ... mos. ... ds.

(Signed) Israel J. Kingloss M. D.

Oct 2, 191.7 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 1820 Fairmount Av

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL. Oct 3, 191.7

20-UNDERTAKER Jack Levis

ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, ... important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8942 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8942

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Beckie Aberdon

(Residence in Baltimore: No. 1424 E. Fayette St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... Unkown ....., 188[illegible]
(Month) (Day) (Year)

7-AGE, 37 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Pasa Nushruk

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Gittel Fruok

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Lewis

(Address)..... 1411 E Balto

15- ROBERT R. CRAUTER

Filed....., 191..... Registrar.

CAUSE OF DEATH to be plain, definite and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct ....., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 1 1917, that I saw h[illegible] alive on Oct 1 1917, and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
Mitral Regurgitation & Stenosis
Uremia
(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation
(Duration)..... yrs. ..... mos. 1 ds.

(Signed)..... Barnard Sacobson M. D.

Oct. 1, 1917. (Address)..... 1[illegible] Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1424 E Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Workmen circle Cemet DATE OF BURIAL, 10-3, 191.7

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8943

CERTIFICATE OF DEATH.

28

D 8943

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeths Home; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Mitchell

(Residence in Baltimore: No. St. Elizabeth's Home St.; 7 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August (Month) 31, (Day) 1910 (Year)

7-AGE, 7 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Norfolk Va

PARENTS.

10-NAME OF FATHER, Luther Mitchell

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Leona Jane King

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leona Mitchell

(Address) Norfolk Va

15-

Filed ....., 191.....

ROBERT T. KRAUTER
OCT 2- 1917
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 1st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1st 1917, to September 30 1917, that I saw h[illegible] alive on September 30 1917, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank D Clyde M. D.

Oct 2, 191.. (Address) 1747 E Fremont St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Oct. 2, 191..

20-UNDERTAKER J R O Holland ADDRESS 1631 D Ham

CAUSE OF DEATH must be given in plain terms. Indefinite answers will not be accepted. Every question must be answered if possible. Omissions will cause delay. Read carefully and see that all information is correct before signing. Your certificate is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8912

CERTIFICATE OF DEATH.

28 D 8912

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2201 Roslyn Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma V. Barry

(Residence in Baltimore: No. 2201 Roslyn Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	White	Single

6-DATE OF BIRTH, May (Month) 30 (Day), 1897 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. 4 mos. 1 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)..... G.D.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Harry S. Barry

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Emma Chandler

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Barry

(Address) 2201 Roslyn ave

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Oct 1 1917, that I saw h.r alive on Oct 1 1917, and that death occurred, on the date stated above, at 3.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. E. Krug M. D.

Oct 2, 1917 (Address) 1012 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Lorraine Cemetery	Oct 3, 1917.
20-UNDERTAKER John O. Mitchell	ADDRESS 1201 W. Fayette

OCT 2- 1917 EUBERT R. KRAUTER

Burial Permit

Spec.—5-19-13—M. & T.—500 Bks.

D 8915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8915

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3833 Clifton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert William Rutherford

(Residence in Baltimore: No. 3833 Clifton Ave St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, May (Month) 11 (Day), 1877 (Year)

7-AGE, 44 yrs. 4 mos. 19 ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman 067
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Paper House

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Henry Rutherford

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER, Annie P. Elwert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. W. Rutherford.

(Address) 3833 Clifton Ave.

15-

Filed OCT 2- 1917, 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 1 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 - 1917, to Sept. 30 - 1917, that I saw him alive on Sept. 30 - 1917, and that death occurred, on the date stated above, at 4.35 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. K. Schilling M. D.

Oct. 1, 1917. (Address) 4107 Liberty Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount. DATE OF BURIAL, Oct. 3, 1917.

20-UNDERTAKER, John O. Mitchell ADDRESS, 1201 W. Fayette

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8946

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1239 Bayard St. St. 21 Ward)

2-FULL NAME Lydia Parks.

(Residence in Baltimore: No. 1239 Bayard St. St.; 64 yrs. 7 mos. 14 ds.)

REGISTERED No. C 79 D 8946

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.-Every item of information should be carefully supplied. AGE should be filled out. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb 16, 1853 (Month) (Day) (Year)

7-AGE: 64 yrs. 7 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Stone.
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

ooo

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: James A. Wilson

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Rebecca Frazier

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James L. Parks

(Address) 1239 Bayard St.

15.

Filed OCT 2 1917, 191 ROBERT B. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 1, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Oct 1 1917.

that I saw h[illegible] alive on Sept. 30, 1917.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Stephen [illegible] M. D.

Oct 1, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount Olivet Cy

DATE OF BURIAL: Oct 3, 1917

20-UNDERTAKER: Jos Jordens Son

ADDRESS: 217 S. Read

Spec.—8-24-14—M. & T.—2000 Bks.

D 8947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8947

CERTIFICATE OF DEATH.

87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Carlisle Place St.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Tuka

(Residence in Baltimore: No. 1711 Carlisle Place St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH. Dec 1, 1910 (Month) (Day) (Year)

7-AGE. 6 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Tuka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Katerin Peter

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Tuka

(Address) 1711 Carlisle Place

15-

OCT 2- 1917 ROBERT B. KRAUTER

Filed....., 191..... Registrar.

CAUSE OF DEATH to be plainly written. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 1 1917, that I saw her alive on Oct 1 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

Probably an acute catarrhal

(Duration) .....yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) acute edema of glottis

(Duration) .....yrs. ..... mos. 1 dy.

(Signed) H. Rungstad M. D.

Oct 1, 191 7 (Address) 604 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Oct 3, 191 7

20-UNDERTAKER Frank Creek & Son

ADDRESS 1106 Eastland Ave

D 8948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175

D 8948

REGISTERED No. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 16 St. ... WARD)

2-FULL NAME ~~John G. Gotz~~ Albert G. Gotz.

(Residence in Baltimore: No. 620 N. Fremont Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs.. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. 20, 1845
(Month) (Day) (Year)

7-AGE, 72 yrs. 6 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Musician
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John G. Gotz

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Rosella Buda

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gotz

(Address) 23 E. Lanvale St.

15-

OCT 2- 1917

Filed ....., 191.... ROBERT B. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally killed by
being run down by Auto

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Mabee Jones M. D.
(Coroner.)

Oct 2, 191 7 (Address) 5 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Oct. 4. 1917
20-UNDERTAKER	ADDRESS
Geo W Little	531 N Fremont Ave

N. B.—Every item of information called for should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Paca, St.; 4 Ward) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew J. Maddall.

(Residence in Baltimore: No. 425 S. Paca St.; 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	white	Single

6-DATE OF BIRTH, not known (Month), (Day), 1879 (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 243
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, John Maddall.

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Eva. Duncute.

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Greblianckas

(Address) 425 S. Paca St.

15-

Filed OCT 3- 1917, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Oct 2 1917, that I saw h im alive on Oct 2 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Albert T. Chambers M. D.

Oct 2 1917. (Address) 1017 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct 4, 1917

20-UNDERTAKER John Greblianckas — ADDRESS 425 S. Paca St

N.B.—Every item of information should be entered. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

D 8950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8950

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 600 Jackson St. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maude White

(Residence in Baltimore: No. 573 Cleveland St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept. 10, 1887
(Month) (Day) (Year)

7-AGE, 30 yrs. 6 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Maid
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Charles White

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Addie Barnes

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie White

(Address) 573 Cleveland St

15-

Filed OCT 3- 1917, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas in Intestines

Acute Indigestion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Poor Water

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Oct 2, 191.7 (Address) 1 E Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Samuel S Hemsley ADDRESS 578 N Fidd

N. B.—Every item of information called for should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Data must be important. See instructions on back of certificate.

D 895[illegible]

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 895[illegible]

1-PLACE OF DEATH

REGISTERED No. C [illegible]

CITY OF BALTIMORE (No. 1821 Maryland ave St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Daniel Frank

(Residence in Baltimore: No. 1821 Maryland ave St. 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: Sept 6, 1843 (Month) (Day) (Year)

7-AGE: 74 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): (House)

9-BIRTHPLACE (State or country): U.S.A.

PARENTS

10-NAME OF FATHER: Jacob Daniel Frank

11-BIRTHPLACE OF FATHER (State or country): U.S.A.

12-MAIDEN NAME OF MOTHER: Elizabeth Ann Stewart

13-BIRTHPLACE OF MOTHER (State or country): U.S.A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Frank

(Address) 1813 Md. Ave

15-

Filed [illegible] 191 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 1st, 191[illegible] (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 19 .191[illegible] to October 1 191[illegible].
that I saw h[illegible] alive on October 1 .191[illegible].
and that death occurred on the date stated above, at 2 30 p.m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 1 mos. 1 ds

Contributory (SECONDARY) Arterio sclerosis

(Duration) indefinite yrs. mos. ds.

(Signed) Howard Ellwood M. D.

October 2nd, 191[illegible] (Address) 530 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Oct 4 .191[illegible]

20-UNDERTAKER: Wm J. Tuckerman — ADDRESS: Norther Ave

N. B.-Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8952 ✓ D 8952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Posey

(Residence in Baltimore: No. 1 day in Hospital St.; ... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Oct. 23 (Month) (Day), 1864 (Year)

7-AGE: 52 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Mark Posey

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Ellin Whittington

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Myers

(Address) Johns Hopkins Hospital

15-

Filed ....., 191..7 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 30 1917, to Oct 1 1917, that I saw him alive on Oct 1 1917, and that death occurred, on the date stated above, at 1160 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration due to Chronic Interstitial Nephritis 6 months standing

(Duration) 6 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) 10 yrs. ... mos. 1 ds.

(Signed) L. L. Bloomfield M. D.

Oct. 1, 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence Rogers Forge Md.

19-PLACE OF BURIAL OR REMOVAL, Pleasant Rest Cem. DATE OF BURIAL, Oct. 3, 191.7.

20-UNDERTAKER Towson Mrs R A Elliott ADDRESS 606 East St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8953 +44 ✓ D 8953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 9 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Eggleston (Eggleston) In Hospital.

(Residence in Baltimore: No. ... St.; — yrs., — mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 28 (Month) 19 (Day) 1868 (Year)

7-AGE, 49 yrs. mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Railway Co.

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Benjamin Eggleston

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Eggleston

(Address) 903 N Bond St.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 2 1917, that I saw him alive on Oct 2 1917, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Surgical Shock

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Face

..... (Duration) 2 yrs. 6 mos. ..... ds.

(Signed) Chas. H. Gilmore M. D.

....., 191... (Address) 58 Hopkins Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 45 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 309 N Bond

Former or usual residence 309 N Bond

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. | DATE OF BURIAL, Oct 4 ....., 191...

20-UNDERTAKER E. Schlosser & Son | ADDRESS 1039 Hanover St

CAUTION—Do not write in this space. Important. See instructions on back of certificate.

Oct 2 - 1917 BOARD OF HEALTH BALTIMORE

Oct 2

Spec.—8-24-14—M. & T.—2000 Bks.

D 8954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8954

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 Lorman St ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Lee Dunkins

(Residence in Baltimore: No. 1837 Lorman St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1917 (Year)

7-AGE, ..yrs. 2 mos. ..ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), city

PARENTS.

10-NAME OF FATHER, Burdie Dunkins

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Maggie McCardell

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burdie Dunkins

(Address) 1837 Lorman St.

15-

Filed....., 191.....

Registrar.

OCT 3- 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/30 1917, to 10/2 1917, that I saw h.. alive on 10/2 1917, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration)...yrs...mos...ds.

(Signed) Burdie Smith, M. D.

....., 191... (Address) 2134 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER Pearce & Wright

ADDRESS 1364 Mc Cane

Cross out words not important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8955 79 D 8955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 84 McKim ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Powell Hackett

(Residence in Baltimore: No. 84 McKim St.; —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored a.a

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W M Brown

(Address) 841 McKim st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1917, to Oct. 1, 1917, that I saw h[illegible] alive on Sept. 20 1917, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

1. Mitral Regurgitation

.....

.....

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

..... (Duration) yrs. 3 mos. ds.

(Signed) H. L. Wilson M. D.

10/2 1917 (Address) 1520 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct. 5, 1917

20-UNDERTAKER Charles B Jones

ADDRESS 235 Pine St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8956

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 8956

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Vine ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henriette Johnson

(Residence in Baltimore: No. 826 Vine St.; 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) — 1 (Day), 1862 (Year)

7-AGE, 55 yrs. 3 mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Lomegy.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Betty Peaker.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Johnson

(Address) 826 Vine St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) — 1 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Oct 1 1917, that I saw h[illegible] alive on Oct 1 1917, and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. C. Link M. D.

Oct 2, 1917 (Address) 1313 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Oct 4, 1917

20-UNDERTAKER Charles B. Jones ADDRESS 235 Pine

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8957

CERTIFICATE OF DEATH.

113 D 8957

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 105 Arlington Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Joseph Mc Dermott

(Residence in Baltimore: No. 105 Arlington Ave St.; 40 yrs., 10 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. November 17, 1876 (Month) (Day) (Year)

7-AGE. 40 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Carpenter (b) General nature of industry, business, or establishment in which employed (or employer). (Horse)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Thomas Mc Dermott

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary C. Quist

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Morcellow McDermott

(Address) 105 Arlington Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 29, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1914, to Sept 29 1917, that I saw h— alive on Sept 29 1917, and that death occurred, on the date stated above, at 1 pm.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 2 ds.

(Signed) R. L. Campbell M. D.

Sept 29 191 7 (Address) 1644 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Peters Cemetery DATE OF BURIAL. Oct 2 191 7

20-UNDERTAKER John J. Howard Son ADDRESS 901 Hollins St.

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 8958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8958

CERTIFICATE OF DEATH.

151 ✓ REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Wicomico St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Bodkin

(Residence in Baltimore: No. 1121 Wicomico St.; ....yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 1 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Born
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), Balto. City, Md

PARENTS.

10-NAME OF FATHER, Bernard F. Bodkin

11-BIRTHPLACE OF FATHER (State or Country), Charleston, W. Va

12-MAIDEN NAME OF MOTHER, Margaret Potter

13-BIRTHPLACE OF MOTHER (State or Country), Norwich, Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. F. Bodkin

(Address) 1121 Wicomico St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 2 1917, that I saw h[illegible] alive on Oct 2 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Premature birth (7 months)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. S. Seabury M. D.

Oct 2, 1917. (Address) 621 Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Oct 3, 1917

20-UNDERTAKER, Dep't H. Cook

ADDRESS 1003 W. Balto

CAUSES OF [illegible] important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8959

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 46 E. Heath ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth L. Mcnally

(Residence in Baltimore: No. 46 E. Heath St. St.; 52 yrs., 9 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Married

6-DATE OF BIRTH, Dec (Month) 23 (Day), 1864 (Year)

7-AGE, 52 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas. Gent.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Louisa Tenny

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace A. Mcnally

(Address) 46 E. Heath st.

15-

OCT 3- 1917

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 1 1917, that I saw h-r alive on Oct 1 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Thurston M. D.

Oct 3rd, 1917. (Address) 1225 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, Oct 3, 1917.

20-UNDERTAKER J. Fred McCully

ADDRESS 130 E. Fort.

D 8960 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 N Carrollton Av ST.: 16 WARD) REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria L. Brodrick

(Residence in Baltimore: No. Institution, Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept. 23, 1844
(Month) (Day) (Year)

7-AGE, 72 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Witness 000
(b) General nature of industry, business, or establishment in which employed (or employer): Institution

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Cornelius Buckley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) Institution

15-

Filed OCT 3- 1917, 191.... MARY C. AN[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arterio Sclerosis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis 7 days (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 3, 1917. (Address) 814 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Md. Inst. for Feeble Minded | DATE OF BURIAL, 10-3-, 1917

20-UNDERTAKER H. C. Branning & Co | ADDRESS 311 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8961

CERTIFICATE OF DEATH.

79 ✓ D 8961

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 Woodward ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. M. Wirth

(Residence in Baltimore: No. 840 Woodward St.; 67 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Nov. 7 (Month), 1832 (Day) (Year)

7-AGE. 84 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): B & O. 031

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Don't Know.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Feuschling

(Address) 840 Woodward St

15-

OCT 3 - 1917

Filed....., 191.....

MARY O. ANDREWS
BUREAU PERMIT OFFICER

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 2nd (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from December 16 1917, to Oct 2 1917, that I saw h in alive on Oct 2 191.., and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Uremic Coma

(Duration) ..yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Edward B. Freeman M. D.

Oct 2, 1917. (Address) 41 W Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. Oct. 5, 1917.

20-UNDERTAKER Mr & Mrs. John W. Tenfel

ADDRESS 801 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8962

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 Druid Hill Ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lah Richardson

(Residence in Baltimore: No. 1237 Druid Hill Ave St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	C-C	Widow

6-DATE OF BIRTH, Unknown 1850
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
67 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic —
(b) General nature of industry, business, or establishment in which employed (or employer): 870

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Palmer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emmie Sears

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard H. Owens

(Address) 1237 D. H. Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 21 1917, to Sept 30 1917, that I saw h[illegible] alive on Sept. 30 1917, and that death occurred, on the date stated above, at 12:[illegible] m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) R. Garland Edmunds M. D.

Oct. 1, 1917. (Address) 1534 D. H. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	Oct 2, 1917

20-UNDERTAKER	ADDRESS
John A. Burke	1117 N. Ave

OCT 3- 1917 HARRY C. ANDREWS BOARD OF HEALTH

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

B 8963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 B 8963

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 W. Cross ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pinkett

(Residence in Baltimore: No. 32 W. Cross St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Blake

(Address) 32 W. Cross St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 191.., to Oct 2 191.., that I saw h[illegible] alive on Oct 1 191.., and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration), ...yrs. 10 mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. several months mos. ds.

(Signed) [signature] M. D.

Oct 2, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 4, 191..

20-UNDERTAKER L. K. Brown's Son — ADDRESS 116 N. Monty

important. See instructions on back of certificate.

OCT 2, 1917 HARRY [illegible] BURIAL PERMIT

D 8961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 ✓

D 8961

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 113 N Amity ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Blackston

(Residence in Baltimore: No. 915 Carley Court. St.; —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE. Col | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rag man
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Blackston

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Irrland

(Address) 114 N Schroeder

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Internal Hemorrhage & Shock Caused by being struck in Chest with a Knife (Homicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. L. Lincoln M. D.

Oct 2, 191... (Coroner) (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn | DATE OF BURIAL, Oct 4, 1917

20-UNDERTAKER Gilbert Brown | ADDRESS 1140 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8965

CERTIFICATE OF DEATH.

X 186 D 8965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Lee Needy.

(Residence in Baltimore: No. 1 da. St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Oct. 18, 1915.
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Chas. Needy.

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Ida K. Mendhunt

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps

(Address) John Hopkins Hosp.

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 3 1917, that I saw h[illegible] alive on Oct 3 1917, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Foreign Body - Trachea.

.....

.....

.....

..... (Duration) ....yrs. —mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) S. J. Crowe M. D.

Oct. 3, 1917 (Address) John Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Shepardstown W. Va

19-PLACE OF BURIAL OR REMOVAL, Shepardstown W. Va

DATE OF BURIAL, Oct. 3, 1917.

20-UNDERTAKER Robert E. Fuller

ADDRESS 221 N Broadway

D 8966 HEALTH DEPARTMENT--CITY OF BALTIMORE D 8966

CERTIFICATE OF DEATH

91

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2455 McCulloh St. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Phillip Myerberg

(Residence in Baltimore: No. 2455 McCulloh St. St.: 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 15, 1885 (Month) (Day) (Year)

7 AGE: 32 yrs. 4 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Clothing Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer):

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9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Lewis

(Address) 1411 E Baltimore St

15 OCT 3 - 1917

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 3, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1917, to Oct. 3 1917.

that I saw him alive on Oct 3, 1917.

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(Of unknown origin)

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Bronchio-pneumonia

(Duration) yrs. mos. 3 ds.

(Signed), S. Wolman M. D.

Oct. 3, 1917 (Address) 2407 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Mishnay Cem Rd

DATE OF BURIAL: 10/4, 1917

20 UNDERTAKER: Jack Lewis

ADDRESS: 1411 E Baltimore St

N.B.—Every item of information should be carefully given, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8967

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8967

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Sinnett

(Residence in Baltimore: No. 2121 - Oak, Lt St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Oct. (Month) 2 (Day), 1917 (Year)

7-AGE, ...yrs...mos...ds.

If LESS than 1 day, 10 hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Michael Sinnett

11-BIRTHPLACE OF FATHER (State or Country) San Francisco Cal

12-MAIDEN NAME OF MOTHER Margaret Michael Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Lousiana Cal.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. M. Sinnett

(Address) 2121 N. Oak St.

15-

OCT 3- 1917 ROBERT R. KRAUTER

Filed ..., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. (Month) 3rd (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2nd 1917, to Oct 3rd 1917, that I saw h— alive on Oct 3rd 1917, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage - Premature child

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Premature infant

(Duration) ...yrs...mos...ds.

(Signed) [illegible] M. D.

Oct 3rd, 1917. (Address) St. Joseph Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs. mos. 10 Hrs ds.

Where was disease contracted, if not at place of death? St. Joseph Hosp

Former or usual residence St Joseph Hosp

18-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, Oct. 4, 1917.

20-UNDERTAKER Henry Storck Son

ADDRESS 1301 E Eager St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8968

CERTIFICATE OF DEATH.

D 8968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp., ST., 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vina C. Swingley (Swingley)

(Residence in Baltimore: No. 436 Pinkney Place St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, May (Month) ..... (Day), 1915 (Year)

7-AGE, 2 yrs. 6 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Otto Swingley

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mollie Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Swingley

(Address) 436 Pinkney Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3rd (Month) ..... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2- 1917, to Oct 3rd 1917, that I saw her alive on Oct 3rd 1917, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Rt Lung

Dr J R Rienhoff

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry M. Conrad M. D.

10-3, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State like Vina

Where was disease contracted, if not at place of death? 436 Pinkney St Balto

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Poplar Md

DATE OF BURIAL, Oct 4, 191.7

20-UNDERTAKER Wm Cook

ADDRESS Bond & Aisquith

important. See instructions on back of certificate.

OCT 3-1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8969 — 28 — D 8969

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Forest St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hesbeth Conway

(Residence in Baltimore: No. 727 Forest St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, June 19, 1876 (Month) (Day) (Year)

7-AGE, 31 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Henry Conway

11-BIRTHPLACE OF FATHER (State or Country), Howard Co

12-MAIDEN NAME OF MOTHER, annie Scott

13-BIRTHPLACE OF MOTHER (State or Country), north Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgianna Conway

(Address) 727 Forest St

15-

Filed....., 191.....

Registrar.

OCT 3- 1917 ROBERT R. KRAETER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Oct 2 1917, that I saw h... alive on Oct 2 1917, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

(a) Laryngeal Tuberculosis

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 3, 1917 (Address) 2311 Hastings

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pathy Hill cemetery — DATE OF BURIAL, Oct. 4, 1917

20-UNDERTAKER James H Dennis — ADDRESS 1305 Eastern Ave

Important. See instructions on back of certificate.

D 8970 HEALTH DEPARTMENT—CITY OF BALTIMORE D 8970

CERTIFICATE OF DEATH.

REGISTERED No. C 182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 28 S. Albemarle ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saml. Marletti

(Residence in Baltimore: No. 28 S. Albemarle St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Unknown ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 35 Year ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fruit
(b) General nature of industry, business, or establishment in which employed (or employer)..... Vendor

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, S. Marletti

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Frank Marletti

(Address)..... Chamberburg Pa.

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1 ....., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicidal Shooting

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Phillip Wm. Bruck M. D.
(Coroner.)

Oct 3, 1917. (Address) 1610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Chamberburg Pa. DATE OF BURIAL, Oct. 4th, 1917

20-UNDERTAKER George F. Ruth ADDRESS 1735 Harford ave

D 8971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D 8971

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 28 S. Albemarle ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfonso Appollinio

(Residence in Baltimore: No. 28 S. Albemarle st

St.; 5 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 40 Years ....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Frank Appollinio

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Marletta

(Address) Chambersburg. Pa.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ autopsy thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) ~~inquest~~ autopsy and ~~Wednesday~~ Tuesday ...find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Homicidal Shooting.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 3..., 1917 (Address) 160 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cemetery.

DATE OF BURIAL, Oct. 4., 1917

20-UNDERTAKER George A. Ruth

ADDRESS 1735 Harford ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 8972

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 ✓

REGISTERED No. C 8972

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1310 Towson St. 24 WARD)

2-FULL NAME Anna Margaret Fuchs

(Residence in Baltimore: No. 1310 Towson St.; yrs. 10 mos. [redacted] ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F | 4-COLOR OR RACE W | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Dec (Month) ..... (Day) , 1916 (Year)

7-AGE ..... yrs. 10 mos. ~ ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Balto Md

PARENTS

10-NAME OF FATHER Wm. Fuchs

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Mary Sailer

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Fuchs

(Address) 1310 Towson St

15

Filed OCT 4 - 1917 HARRY C. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct (Month) 3 (Day) , 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1917, to, Oct 3 1917.

that I saw h[illegible] alive on Oct 2, 1917

and that death occurred, on the date stated above, at 7.10 Am.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Acute Dyspepsia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed), Dr. J. Kaplan M. D.

Oct 3, 1917 (Address) 2048 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Holy Cross | DATE OF BURIAL Oct 6, 1917

20-UNDERTAKER [illegible] | ADDRESS 310 [illegible]

N. B.—[illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8973

CERTIFICATE OF DEATH.

28 ✓ D 8973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Carey St.: 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Margaret A Smith

(Residence in Baltimore: No. 1132 W. Pratt St.: Life-time yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 31 (Day), 1890 (Year)

7-AGE, 27 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Peter Burns

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Johanna Whalen

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry W. Smith

(Address) 1132 W. Pratt St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18 1917, to Oct 1 1917, that I saw h-r alive on Sept 30 1917, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Years Months

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Henry W. Smith M. D.

Oct. 1, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Peters	Oct 5th, 1917.

20-UNDERTAKER	ADDRESS
John J. Reilly	1200 W. Lombard

OCT 4 - 1917 MARY C. AGNEW

important. See instructions on back of

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 8971

CERTIFICATE OF DEATH

150 D 8974

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1509 Carswell ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence A Burker

16 Hours

(Residence in Baltimore: No. 1509 Carswell St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: October (Month) 2d (Day), 1917 (Year)

7-AGE: Fifteen Hours yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) 1509 Carswell St

PARENTS

10-NAME OF FATHER Charles W Burker

11-BIRTHPLACE OF FATHER (State or country) Baltimore

12-MAIDEN NAME OF MOTHER Sarah Blakeley

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles W Burker

(Address) 1509 Carswell St

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1917, to, Oct 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Congenital Valvular Disease of the Heart

(Duration) 16 Hours

Contributory (SECONDARY) Coma

(Duration) 16 Hours

(Signed) Hayden Westbrook M D

(Oct 3 1917) [Address] 1615 Gorsuch Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudenn Park

DATE OF BURIAL: Oct 4, 1917

20-UNDERTAKER: William Cook

ADDRESS: 502 E 16th

OCT 4- 1917 MARET C. ANDERSON REGISTRAR

Back of Certificate. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8975

CERTIFICATE OF DEATH.

15 D 8975

1-PLACE OF DEATH Women's Hospital

REGISTERED No. C

CITY OF BALTIMORE: (No. 5 ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Mankins, Jr.

(Residence in Baltimore: No. 506 N. Stricker St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. Oct. 3 (Month) (Day), 1917. (Year)

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Mr. Wm. F. Mankins.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Anna Kreighbaum

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Wm Mankins
per (Informant) Martha E. Freund, R.N.
(Address) Hosp. Women & Md.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 3rd. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 ,
that I saw h[illegible], alive on Oct 3 1917,
and that death occurred, on the date stated above, at 11 3/4 a. m.
The CAUSE OF DEATH* was as follows:
Asphyxiation, Drowning
due to a Difficult Delivery
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John M. F. Burland M. D.
Oct 3, 1917. (Address) 4 W. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. County Cemetary
DATE OF BURIAL. Oct 4, 1917

20-UNDERTAKER Christian Miller
ADDRESS 2334 Jefferson St

Important. See instructions on back.

D 8976

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 8976

1 PLACE OF DEATH Robert Garrett Hospital — REGISTERED NO. C 37

CITY OF BALTIMORE: (No. 27 North Carey St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Shores

(Residence in Baltimore: No. 828 N. Stricker St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: April (Month) 2 (Day), 1917 (Year)

7-AGE: yrs. 6 mos. 1 ds. — If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: Bert. Shores.

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Ada. Benton.

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Shores.

(Address) 828 N. Stricker

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1917, to, October 3 1917, that I saw her alive on October 3 1917, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(Duration) — yrs 6 mos. 1 ds.

Contributory (SECONDARY): Marasmus

(Duration) — yrs 6 mos. 1 ds.

(Signed), John C. [illegible] M. D.

Oct 4, 1917. [Address] 27 N. Carey St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 18 ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death? Baltimore Md

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL: London Pk. Cem. — DATE OF BURIAL: 10/4 191 7

20-UNDERTAKER: Bertram W. Gore. — ADDRESS: 1723 W. Lafay

TION is very important. See instructions on back of certificate.

D 8977 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 8977

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 128 Grace Court ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dallie Newman

(Residence in Baltimore: No. 128 Grace Court St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, Col | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Foster

(Address) 128 Grace court

15-

Filed OCT 4- 1917, 191..... HARRY C. ANDERS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic tubular Heart Disease

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) C. L. Lindsay M. D.
(Coroner)

Oct 3, 191.. (Address) 317 N Carrollo

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery | DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER Geo H Hooper | ADDRESS 602 Little Rock

CAUSE OF DEATH must be filled in by physician. Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8973 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 8973

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 403 S. Ann ST.; V WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Wiesnewski

(Residence in Baltimore: No. 403 S. Ann St.; yrs., 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH Nov 14" 1916
(Month) (Day) (Year)

7-AGE, — yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Joseph Wisnewski

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Josephine Kowska

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Wisnewski

(Address) 403 S. Ann st.

15-

Filed....., 191.....
Registrar.

OCT 4- 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2", 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1- 191 7, to Oct 1- 191 7, that I saw her alive on Oct 1- 191 7, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Gastritis & Intestinal colitis

..... (Duration) ....yrs. ....mos. 1 3 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Heart failure

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Wm. A. Shuttleff M. D.

Oct 2, 191 7. (Address) 1621 E Baltimore st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL. Oct. 4, 191 7.

20-UNDERTAKER Stephen J. Fialkowski ADDRESS 1019 S. Kenwood ave.

Important: See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8979

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 D 8979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Novels Alley ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Dunn

(Residence in Baltimore: No. 902 East Chase St. St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 12, 1877
(Month) (Day) (Year)

7-AGE, 40 yrs. 1 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Dunn

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen O'Connell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Dunn

(Address) 902 E. Chase St.

15-

Filed....., 191.....

Registrar.

OCT 1- 1917

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24th 191 , to Oct. 3rd 1917 , that I saw h alive on Oct. 2nd 1917 , and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged Heart

(Duration) yrs. mos. ds.

(Signed) Ernest A. Dr. Riley M. D.

Oct 3rd, 1917. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Oct 6, 1917.

20-UNDERTAKER W. C. Woodfield

ADDRESS 917 Eastern Ave

D 8980

HEALTH DEPARTMENT—CITY OF BALTIMORE

69 D 8980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Jos. Hospital ST. 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Gordey,

(Residence in Baltimore: No. 229 S Dallas St.; Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	Col	Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), (Year)

7-AGE,	If LESS than 1 day,
37 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Girl
(b) General nature of industry, business, or establishment in which employed (or employer): 090

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, William Harvey

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Small

(Address) 229 S Dallas

15- HARRY O. ANDREW

Filed OCT 1 1917, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Downey (Coroner.) M. D.

Oct 1, 1917. (Address) 916 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Oct 4 1917

20-UNDERTAKER Daniel Easton ADDRESS 916 Eastern

CAUSE OF DEATH. Important. See instructions on back of certificate.

D 8981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8981

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 539 McMahon ST.: 14 WARD) REGISTERED No. C 103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Ball

(Residence in Baltimore: No. 539 McMahon St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fmale	Colo	Single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1897 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Room Keeper 070
(b) General nature of industry, business, or establishment in which employed (or employer): In Private family

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wally Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Victoria Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie

(Address) 539 McMahon

15-

OCT 2 - 1917

Filed ....., 191... MARET C. ANDREWS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inc Exp (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Prostration due to (Shock from Laparotomy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bad Acid

(Duration) yrs. mos. ds.

(Signed) Reynold Thos (Coroner,) M. D.

Oct 2, 191... (Address) 539 McMahon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Oct 5, 1917
20-UNDERTAKER	**ADDRESS**
James H Dennis	1303 Druid Hill Ave

CAUSE OF DEATH must be stated plainly and accurately. Every item is important. See instructions on back of certificate.

D 8982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8982

CERTIFICATE OF DEATH.

REGISTERED No. C 78

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 314 N Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George R. Taylor

(Residence in Baltimore: No. 314 N Vincent St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, June (Month) 15 (Day), 1863 (Year)

7-AGE, 54 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waste Paper Baler
(b) General nature of industry, business, or establishment in which employed (or employer): Jos Himelhoch

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, — Taylor

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Taylor

(Address) 314 N Vincent St

15-

Filed....., 191.....

Registrar.

OCT 4 - 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) yrs. 3 mos. 2 ds.

(Signed) James M. Fenton M. D. (Coroner.)

(Oct 3, 1917.) (Address) 2 W. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, OCT 5 1917

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8983

1-PLACE OF DEATH Bridley & Pellmyer Sanatorium REGISTERED NO. C

CITY OF BALTIMORE: (No. 2 Fort N. Charles ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David N. Krebs

(Residence in Baltimore: No. 650 W. Franklin St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 7 (Month) (Day), 1850 (Year)

7-AGE, 66 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, Not Known.

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Krebs

(Address) 4714 E. Fort Avenue

15- Filed OCT 4 - 1917, 191.... ROBERT B. KRAUTER Registrar.

Important: See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 191.., to Oct 4 191.., that I saw h.. alive on Oct 3 191.., and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

"Uraemia"

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cirrhosis prostate

Exhaustion (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm N. Magruder M. D.

Oct 4, 191.. (Address) 1102 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 650 W. Franklin St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Oct 6, 191..

20-UNDERTAKER	ADDRESS
McLean Cook	501 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8981

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 8981

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Huntington Ave. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Meehan.

(Residence in Baltimore: No. 2225 Huntington Ave. St.: 40 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown ....., 1866.
(Month) (Day) (Year)

7-AGE, 51 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dan Smith

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Sheridan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. Meehan
(Address) 2225 Huntington Ave.

15-
Filed....., 191.....
OCT 4 1917 ROBERT P. KRAUTER
Registrar.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October. 2nd., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27th 1917, to Oct. 2nd 1917, that I saw her alive on Oct. 2nd 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
.....
.....
..... (Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Age and High Blood Pressure
..... (Duration) 2 yrs. ... mos. ... ds.

(Signed) Lucile L. Stewart M. D.
Oct. 3rd, 1917. (Address) 2207 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Oct. 5, 1917
20-UNDERTAKER	ADDRESS
Chas. F. Love & Son	1700 Druid Hill Ave

D 8985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8985

CERTIFICATE OF DEATH.

169

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mouth of Wolfe St. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J Donovan

(Residence in Baltimore: No. 225 S. Spring Ct St. 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer)..... 506 O'B

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm. Donovan

(Address)..... Back St Cent

15-

OCT 4 - 1917 ROBERT E. KRAUSE

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Drowning

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed) Clarence Ryan Coroner M. D.

9/28, 191.. (Address) 610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

DATE OF BURIAL, OCT 3 1917

20-UNDERTAKER Commissioner Health.

ADDRESS

CAUSE of DEATH important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 8986

CERTIFICATE OF DEATH

104

D 8986

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1014 N. Durham 7 St.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Georgia Jones

(Residence in Baltimore: No. 1014 N. Durham St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): —

6 DATE OF BIRTH: November (Month) 25 (Day), 1916 (Year)

7 AGE: yrs. 10 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): ow

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Jones

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lucinda Maddox

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucinda Maddox sr.

(Address) 1029 N. Wolfe

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 2 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~17~~ Sept, 1917, to. oct 2 1917, that I saw her alive on oct 2, 1917, and that death occurred, on the date stated above, at 8.35 p. m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

(Duration) yrs. mos. 14 ds

Contributory (SECONDARY) Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) W. C. Sandrock M. D.

Oct. 3, 1917 (Address) 7242 N. Broadway,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Oct 5, 1917

20 UNDERTAKER: Wm. J. G. Locke

ADDRESS: 1302 Jefferson

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

OCT 1 - 1917 ROBERT R. KRAETZER

Spec.—8-24-14—M. & T.—2000 Blks.

D 8987 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 8987

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 W. Preston St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Shinners,

(Residence in Baltimore: No. 321 W. Preston St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ...September..... 1 .....
(Month) (Day) (Year)

7-AGE. 69 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sam O. Shinners

(Address)..... 321 W. Preston St.

15- OCT 4- 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1 1917, to Oct. 2d, 1917, that I saw h[illegible] alive on Oct. 1st 1917, and that death occurred, on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Filled a Reservoir
Hemorrhage (Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration)..... yrs. ....mos. ....ds.

(Signed) A. Jos. Ellis M. D.
Oct 2d, 1917. (Address) 724 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER Edw. W. Pyle

ADDRESS 903 Edmondson Ave Catonsville

Spec.—8-24-14—M. & T.—2000 Bks.

D 8988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8988

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1655 Carswell St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Inf nt of Anna & Clarence Foehler

(Residence in Baltimore: No. 1655 Carswell St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 2, 1917 (Month) (Day) (Year) 1

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 2 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Clarence Foehler

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Margaret May

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Foehler

(Address) 1655 Carswell St

15-

Filed ....., 191.....

ROBERT N. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 4 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 4 1917, that I saw him alive on Oct 3, 1917 191, and that death occurred, on the date stated above, at 2-30 Am.

The CAUSE OF DEATH* was as follows:

.....Congenital Atelactasis.....

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ...7 months foetus.....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. Hartman M. D.

....., 191... (Address) 1611 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Redeemer	Oct 4, ... 191..
20-UNDERTAKER Lilly & Zobe	ADDRESS 403 Stricker St

D 8989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8989

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marian Wilcox.

(Residence in Baltimore: No. Goldsboro N C St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Boy

6-DATE OF BIRTH, Oct 17, 1911
(Month) (Day) (Year)

7-AGE, 5 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N C,

PARENTS.

10-NAME OF FATHER. A D. Wilcox,

11-BIRTHPLACE OF FATHER (State or Country). Tenn,

12-MAIDEN NAME OF MOTHER Ada. Inman,

13-BIRTHPLACE OF MOTHER (State or Country). N Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A D Wilcox

(Address) Tenn

15-

Filed OCT 4 - 1917, 191.... ROBERT E. KRAMER Registrar.

Burial Permit Issued

CAUSE OF DEATH must be stated by physician or coroner. Every question must be answered if possible. Omissions cause delay. Typewriting or printing is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism, Left Hypochondrium,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 4, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 2/ ds. In the State.....yrs.....mos. 36 ds.

Where was disease contracted, if not at place of death? Goldsboro N C

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Goldsboro N. C. DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER E. N. Ford. ADDRESS 1703 N Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 8990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721, Orleans ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Dorsey

(Residence in Baltimore: No. 1721 Orleans St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, Dec. 31, 1895
(Month) (Day) (Year)

7-AGE, 21 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Stevenson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Dorsey

(Address) 1721 Orleans St.

15-

Filed ....., 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 2 1917, to Oct. 3 1917, that I saw her alive on Oct. 2, 1917, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. ? mos. ds.

(Signed) L. P. Thein M. D.

10/20, 191.. (Address) 1520 Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asher, Conn. DATE OF BURIAL, Oct. 5, 191.7

20-UNDERTAKER Wm R A Elliott ADDRESS 5-06 East

Spec.—8-24-14—M. & T.—2000 Bks.

D 899 X

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 899 X

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 Brunt ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard James Myers

(Residence in Baltimore: No. 1828 Brunt St.; ....yrs., 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July 1, 1917 (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ood

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, James Myers

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Isabella Forman

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Reid Myers

(Address) 316 N. Fulton Ave.

15-

OCT 4- 1917

ROBERT B. KRAUTER

Filed....., 191.... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28 1917, to Oct. 4 1917, that I saw h.. alive on Oct 3 1917, and that death occurred, on the date stated above, at 1.50 A.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 7 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Paul Brown M. D.

Oct. 4, 191.. (Address) 1837 Bruns St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Oct. 5, 1917.

20-UNDERTAKER Mrs. Mrs. John W. Tempel — ADDRESS 801 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8992

CERTIFICATE OF DEATH.

104

D 8992

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes. Moss

(Residence in Baltimore: No. 816 S. Bond St.: yrs., 7 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Feb. (Month) 11 (Day), 1910 (Year)

7-AGE, ...yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Wiley. Moss

11-BIRTHPLACE OF FATHER (State or Country). Russian Poland

12-MAIDEN NAME OF MOTHER Anna Baker

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Moss

(Address) 816 S. Bond

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Oct 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 9.45 p.m.

The CAUSE OF DEATH* was as follows:

Cystitis & Nephritis & Edema Cerebri

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis Chronic

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Jno. D. Chambers M. D.

Oct 4, 1917 (Address) 1621 E. Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER Wm Fiallkowski ADDRESS 1618 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8993

CERTIFICATE OF DEATH.

15 ✓ D 8993

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 N Carey St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena A Rudis

(Residence in Baltimore: No. 1631 N Carey St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 2, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph S. Rudis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lena J Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph S. Rudis

(Address) 1631 N. Carey St.

15- OCT 4 - 1917 ROBERT B. KRAUTZ

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 4 1917, that I saw h.. alive on Oct 3 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 Mos. after Labor

(Duration) 0 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) R. T. Campbell M. D.

Oct 4, 191.. (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct 5, 191..

20-UNDERTAKER Mrs A Rohde Sons

ADDRESS 730 Pa Ave

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8994

CERTIFICATE OF DEATH.

92

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1414 Mulberry ST.) 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Hamske

(Residence in Baltimore: No. 1414 Mulberry St.) 45 yrs. 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, Nov. (Month) 19 (Day), 1871 (Year)

7-AGE, 45 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Butler Co Ind

PARENTS.

10-NAME OF FATHER Thomas R. Tully

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Amora McCormick

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Hamske

(Address) 1414 Mulberry

15-

Filed....., 191.....

Registrar.

OCT 4- 1917

ROBERT B. KRAUSER
REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 3d (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Oct 3 1917, that I saw her alive on Oct 3d 1917, and that death occurred, on the date stated above, at 4.00 p.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) H. H. Hamm M. D.

Oct 4, 191.. (Address) 831 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Oct. 6.., 1917

20-UNDERTAKER F. A. Lahmer

ADDRESS 703 Hamm

Important: See instructions on reverse side.

Spec.—8-24-14—M. & T.—2000 Bks.

D 8995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8995

CERTIFICATE OF DEATH.

92

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Register ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rawlins

(Residence in Baltimore: No. 416 N. Register St.; —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Rawlins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Roberts

(Address) 416 N. Register St

15-

Filed....., 191.....

Registrar.

OCT 5 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 3 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1917, to Oct. 2, 1917, that I saw him alive on Oct 2, 1917, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Cachexia

Senility

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Robert J. Green M. D.

Oct. 3, 1917. (Address) 120½ Division St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, National

DATE OF BURIAL, Oct 7, 1917.

20-UNDERTAKER John W. Henderson

ADDRESS 31 N Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D 8996 D 8996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Bethel ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Gibson

(Residence in Baltimore: No. 309 S. Bethel St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored a. 4

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH, Dec. 15, 1901 (Month) (Day) (Year)

7-AGE, 15 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Gibson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lena Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Gibson

(Address) 309 S. Bethel St

15-

Filed ....., 191.....

OCT 5 - 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1917, to Oct. 3 1917, that I saw her alive on Oct. 3, 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ....yrs. 3 mos. ....ds.

(Signed) L. K. Jamison M. D.

Oct. 4, 1917 (Address) 520 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER John W Henderson

ADDRESS 31 N Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D 8997. HEALTH DEPARTMENT—CITY OF BALTIMORE D 8997.

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Gorsuch ave ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etta May Hyatt

(Residence in Baltimore: No. 702 Gorsuch ave St.; Lives ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 14 (Day), 1866 (Year)

7-AGE, 51 yrs. 4 mos. 18 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School teacher
(b) General nature of industry, business, or establishment in which employed (or employer) 068

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Governer Hyatt

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Emma C Todd

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Governeur Hyatt

(Address) 702 Gorsuch Ave.

15-

Filed ....., 191.... OCT 5 1917 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Oct 2 1917, that I saw h.r alive on Oct 2 1917, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage right
Left hemiplegia

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. E. Knapp M. D.

Oct 4, 1917. (Address) 1002 N Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER John C. Mitchell

ADDRESS 1201 W. Fayette

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8993

CERTIFICATE OF DEATH.

19 ✓ D 8993

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Ramsey ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd N. Shipley

(Residence in Baltimore: No. 1816 Ramsey St. St.: Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 23 (Day), 1912 (Year)

7-AGE, 4 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Lloyd Shipley

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Maggie Pilcher

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lloyd N. Shipley

(Address) 1816 Ramsay St.

15-

Filed OCT 5- 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1917, to Oct 2 1917, that I saw h.m alive on Sept 30 1917, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) 1 yrs. mos. 10 ds.

(Signed) J. M. Labenger M. D.

Oct 7, 1917. (Address) 17 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Oct. 5, 1917.

20-UNDERTAKER W B Crothers

ADDRESS 2 N Fulton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 8999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8999

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Ethug ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Denby (Denby)

(Residence in Baltimore: No. 1119 Ethug St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, March 15, 1856 (Month) (Day) (Year)

7-AGE, 61 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Gleaves

(Address) 1119 Ethug St

15-

OCT 5 - 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1917, to Oct 3 1917, that I saw her alive on Oct 2 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) Don't Know yrs. ..... mos. ..... ds.

(Signed) Edward L Jenkins M. D.

Oct 4, 1917. (Address) 1116 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cemetery

DATE OF BURIAL, Oct 5, 1917

20-UNDERTAKER Geo H Holland

ADDRESS 1631 Div Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

D 9000

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Aisquith St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Forrest Preston

(Residence in Baltimore: No. 1216 Aisquith St.

St.; 59 yrs., — mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 27, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. — mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 237
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John Forrest

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. L. Preston

(Address) 1216 Aisquith St

15-

OCT 5 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21st 1917, to Oct 4th 1917, that I saw her alive on Oct 4th 1917, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 2 ds.

(Signed) E. M. C. Tucker M. D.

Oct 5, 1917. (Address) 1114 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER Henry Horck Son

ADDRESS 1301 E. Eager St.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9001 — 151 ✓ — D 9001

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 Wilkins Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha L Jenkins

(Residence in Baltimore: No. 2528 Wilkins Ave St.; — yrs., — mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 1st (Day) 191? (Year)

7-AGE, — yrs. — mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thomas Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Georgia L. Moore

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Jenkins

(Address) 2528 Wilkins Ave

15- Filed OCT 5- 1917 HARRY C. ANDREWS Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 3rd (Day) 191? (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 191? to Oct 3rd 191?, that I saw h— alive on Oct 2 191?, and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Cyanosis

(Duration) ...yrs. ...mos. 2 ds.

(Signed) Edw Crumbacker M. D.

Oct 4, 191? (Address) 817 Fawkes

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Good Shepherd Howard Co — DATE OF BURIAL, Oct 5..., 191?

20-UNDERTAKER Easton Sons. — ADDRESS Ellicott City

Spec—5-19-13—M. & T.—500 Bks.

D 9002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9002

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 130 gN Fremont Av ST.; 15 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Albert Mingo & Ella Ringgold

(Residence in Baltimore: No. 130 gN Fremont Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, October 4, 1917
(Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, ...hrs. or 20 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Albert Mingo

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ella Ringgold

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Augustus

(Address) 130 g Fremont Ave.

15- OCT 5 - 1917 HARRY C. ANDREWS

Filed ..., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1917, to Oct 4 1917, that I saw h[illegible] alive on Oct 4 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Asphyxiation

20 minutes
(Duration) ...yrs. ...mos. ...dys.

CONTRIBUTORY (Secondary) Prolonged labor

(Duration) ...yrs. ...mos. 2 ds.

(Signed) H S McCard M. D.

10/4, 191.7 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Peters	Oct 5, 1917
20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 n Bway

D 9003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 ✓

D 9003

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1440 N. Mount St. 15 WARD)

2-FULL NAME Benjamin F. Atkins

(Residence in Baltimore: No. 1440 N. Mount

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Color	Single

6-DATE OF BIRTH, July (Month) 5 (Day), 1914 (Year)

7-AGE, ...yrs. 3 mos. ...ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Father attorney

11-BIRTHPLACE OF FATHER, (State or Country) [illegible] Va

12-MAIDEN NAME OF MOTHER, [illegible] St Johns

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1440 N. Mount

15-

Filed OCT 5 1917, 191... HARRY C. ANDREWS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ...(Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Private Practice)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Duke Lumbago

(Duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

(Coroner.)

Oct 8, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 5, 1917
20-UNDERTAKER Edward Ruggold	ADDRESS 1343 Carey st

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9004

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

138 D 9004

REGISTERED No. C.....

1-PLACE OF DEATH Hahnemann Genl Hosp

CITY OF BALTIMORE: (No. 1122 N. Mount ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Valentina Wells

(Residence in Baltimore: No. 826 N. Stricker St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, December 8, 1876
(Month) (Day) (Year)

7-AGE, 40 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, John Wells

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Annie Price

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel L. Wells

(Address) 826 N. Stricker St.

15-

OCT 5- 1917

Filed....., 191.....

HARRY G. ANDREWS
DEPUTY REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 28 1917, to Oct. 4 1917, that I saw her alive on Oct 4 1917, and that death occurred, on the date stated above, at 5- P. m.

The CAUSE OF DEATH* was as followa:

Hypostatic Pneumonia

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) E. Champaign Tuberculosis

..... (Duration) ....yrs. ....mos. 7 ds.

(Signed) Maurice E. Rhamer M. D.

Oct. 4, 1917. (Address) 3300 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 826 N. Stricker St.

Former or usual residence 826 N. Stricker St, City.

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md. DATE OF BURIAL, Oct 6 191..

20-UNDERTAKER Edward Gore ADDRESS 1723 N. Gilmor St

Spec.—5-19-13—M. & T.—500 Bks.

D 9005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9005

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Ruskin Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria L. Shaffer

(Residence in Baltimore: No. 2223 Ruskin Av St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widow

6-DATE OF BIRTH, Unknown, 1852
(Month) (Day) (Year)

7-AGE 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Chalmers

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Anne Wilhelm

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma L. Chalmers

(Address) 2223 Ruskin Ave.

15- SEP 5 - 1917 HARRY D. SHREVE

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Oct 2 1917, that I saw h.. alive on Oct 2 1917, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank Ebaugh M. D.

Oct 11, 191... (Address) 714 N. Mt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Oct 5, 191 7
20-UNDERTAKER	ADDRESS
H. Fahey & Son	606 Lafayette

D 9006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9006

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1232 Druid Hill St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Beatrice Rice

(Residence in Baltimore: No. 1232 Druid Hill St. Yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colo

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1917 (Year)

7-AGE, ... yrs. 3 mos. 28 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

880

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Frederick Thomas

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Sadie Rice

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Rice

(Address) 1232 Druid Hill Ave

15-

Filed ..., 191...

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) S. G. R. Gutman M. D.

(Coroner.) 5-7-yrs. ... M. D.

..... 5 ....., 191 7 (Address) 819 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Sept 8, 1917

20-UNDERTAKER Samuel P. Hemsley

ADDRESS 5[illegible]

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 9007

CERTIFICATE OF DEATH.

115 D 9007

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Hollins ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Amelia Caroline Henning

(Residence in Baltimore: No. 2000 Hollins St.; 40 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Widow

6-DATE OF BIRTH, July 31, 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. 2 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, Christian Fahlsen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Magdelene Nagle

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. E. H. Henning

(Address) 2000 Hollins St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Oct 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 8 40 a m.

The CAUSE OF DEATH* was as follows:

Emphysema of both Lungs

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pleurisy Left Side

(Duration) 2 yrs. mos. ds.

(Signed) Thos. C. Todd M. D.

Oct. 4, 1917. (Address) 735 N. Collington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER Geo. A. Gerber ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9003 D 9003

CERTIFICATE OF DEATH.

REGISTERED NO. C 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Gough St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Lee Erdbrink

(Residence in Baltimore: No. 2011 Gough St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 9th (Month) (Day), 1864 (Year)

7-AGE, 53 yrs. 8 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): at Home 037

9-BIRTHPLACE, (State or Country), Gloucester Co. Va.

PARENTS.

10-NAME OF FATHER. James Lee.

11-BIRTHPLACE OF FATHER (State or Country), Gloucester Co Va

12-MAIDEN NAME OF MOTHER Ann Kurfman

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Erdbrink

(Address) 2011 Gough St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3rd (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1 1916, to Oct. 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 3 48 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. H. Magruder M. D.

10/3, 191.. (Address) 1106 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Oct. 5, 1917

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 N Wolfe St

Industrial. See instructions.

OCT 4 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9009 D 9009

CERTIFICATE OF DEATH.

138

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise E. Lehman

(Residence in Baltimore: No. 1508 E. Chase St St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. 5, 1895 (Month) (Day) (Year)

7-AGE, 22 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Lehman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Susie Baxter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps

(Address) Johns Hopkins Hosp.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 3 1917, that I saw h[illegible] alive on Oct 3 1917, and that death occurred, on the date stated above, at 1135 P. m.

The CAUSE OF DEATH* was as follows:

Intra partum Eclampsia

7 hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema 5 hours

(Duration) yrs. mos. ds.

(Signed) John Rheumpt M. D.

Oct 4, 191 7. (Address) JHH

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1508 E. Chase St

19-PLACE OF BURIAL OR REMOVAL, Elkton Md — DATE OF BURIAL, October 7, 1917

20-UNDERTAKER George Schilling & Sons — ADDRESS 1126 E. Monument St

D 9010

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

D 9010

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 517 Calander Jr St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Clark

(Residence in Baltimore: No. 517 Calanders St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ~~April~~ Mar 26 (Month) ~~1~~ (Day), 1917 (Year)

7-AGE: ..... yrs. 6 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Wm Clark

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Mary a Monkley

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Clark

(Address) 517 Calanders st

15.

Filed OCT 5 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 5 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1917, to. Oct 4 191 .
that I saw h— alive on Oct 3, 191 .
and that death occurred, on the date stated above, at 4 4 m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. 1 mos. ..... ds

Contributory (SECONDARY) Indigestible food.

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Hopkins Bain M. D.

Oct 5, 191 (Address) 247 Calv

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peters — DATE OF BURIAL: Oct 5th, 1917

20-UNDERTAKER: John J Fields — ADDRESS: 1200 W Fayette

State CAUSE OF DEATH in plain terms. Certificate is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9011 **CERTIFICATE OF DEATH.** 37 D 9011

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Jones

(Residence in Baltimore: No. St. Elizabeth's Home St.; 4 yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	

6-DATE OF BIRTH, August ....., 1913.
(Month) (Day) (Year)

7-AGE, 4 yrs. 2 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Edmonds Co.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Louisiana

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1917, to Oct 2 1917, that I saw h.. alive on Oct 2 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....Acute Enteritis

..... (Duration).....yrs.....mos. 13 ds.

CONTRIBUTORY (Secondary) Hereditary Lues

..... (Duration).....yrs.....mos.....ds.

(Signed) Frank L. Cyr M. D.

Oct 5, 191... (Address) 1937 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	OCT. 5 - 1917
20-UNDERTAKER	ADDRESS
per Wm. E. WOODALL.	

OCT 5 - 1917 ROBERT R. [illegible] Burial Permit [illegible]

Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9012

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 9012

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Higgs

(Residence in Baltimore: No. 305 W 29th St St.; ....yrs., 9 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 19, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 006

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Higgs

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Myrtle Pettis

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 5 1917, that I saw h m alive on October 5 1917, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis. Acute indigestion.

..... (Duration)....yrs. 9 mos....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs....mos....ds.

(Signed) Henry B. Conrad M. D.

Oct 4..., 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 16 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 305 W. 29th St

19-PLACE OF BURIAL OR REMOVAL, Mt Marys. Cem Hampden — DATE OF BURIAL, 10-6, 191.7

20-UNDERTAKER Townsend & Son — ADDRESS 3617 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9013

CERTIFICATE OF DEATH.

64 D 9013

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Ostend ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Cuddy

(Residence in Baltimore: No. 13 E. Ostend St.; 53 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Dont Know, ... (Month) ..... (Day) ..... (Year)

7-AGE, 81 ..... yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Cuddy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jas. Cuddy

(Address)..... 13 E. Ostend St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 2 '17 ..... (Month) ..... (Day) ..... (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Oct 2 '17, that I saw h[illegible] alive on Oct 1 1917, and that death occurred, on the date stated above, at 1000 m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) 1 yrs. 7 mos. ..... da.

(Signed) [illegible] M. D.

Oct 4, 1917. (Address) 1228 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER M. J. Flynn

ADDRESS 1402 Light

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9014

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1850 Light St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James F. Lanahan

(Residence in Baltimore: No. 1850 Light St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1868. (Year)

7-AGE, 48 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Retail Grocery (045) (b) General nature of industry, business, or establishment in which employed (or employer): Grocery man

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Cornelius Lanahan

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Mary Ward

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Lanahan

(Address) 1850 Light St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 2 1917, that I saw h alive on Oct 2 1917, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) ....yrs. 18 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 4, 1917 (Address) 1228 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER M. S. Flynn

ADDRESS 1422 Light St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 ✓ REGISTERED No. D 9015

D 9015

1 PLACE OF DEATH

CITY OF BALTIMORE: (No 871 Linden Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Ellen Davis

(Residence in Baltimore: No. 871 Linden Ave St.; 50 yrs. 5 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Col-

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: March (Month) 31 (Day), 1850 (Year)

7-AGE: 67 yrs. 6 mos. 4 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION (a) Trade, profession or particular kind of work; (b) General nature of industry, business, or establishment in which employed (or employer): Laundress 841

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Oscar Armstead

11-BIRTHPLACE OF FATHER (State or country): Va.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Paul Davis

(Address) 871 Linden Ave.

15- Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30, 1917, to, Oct 4 1917, that I saw h[er] alive on Oct 3 1917, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) about yrs — mos — ds.

Contributory (SECONDARY) Hypertrophied Heart

(Duration) — yrs 6 mos. ds.

(Signed), H. C. Altaffer M. D.

Oct 4, 1917. [Address] 817 Hamilton Ave

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENT OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel cemetery

DATE OF BURIAL: Oct. 6. 1917. 191

20-UNDERTAKER: Felix B. Pye

ADDRESS 1022 E. Mulberry

N. B.—Every item of information should be carefully supplied, so that it may be properly WRITE PLAINLY. Use ink. Do not abbreviate. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. ATTENDING PHYSICIAN'S SIGNATURE AND ADDRESS IS VERY IMPORTANT.

D 9016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 D 9016

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Park Jermond ST. 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Deamerett

(Residence in Baltimore: No. Fort Heights Ave. Belvidere Ave. St.; yrs., 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Apr. (Month) 20 (Day), 1872 (Year)

7-AGE. 45 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Bartender
(b) General nature of industry, business, or establishment in which employed (or employer). 044

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Alberis Deamerett

11-BIRTHPLACE OF FATHER (State or Country) Switzerland

12-MAIDEN NAME OF MOTHER. Mary A Bowers

13-BIRTHPLACE OF MOTHER (State or Country) Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Deamerett

(Address) Park Heights Ave

15-

Filed OCT 5 1917, 191.... ROBERT B. KRAUTER Serial Permit Clerk

Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Durntion) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Durntion) ....yrs. ....mos. ....ds.

(Signed) Thos. H. Morrison M. D. (Coroner.)

Oct 5th 1917 (Address) 7632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Holy Redeemer Cem. DATE OF BURIAL, Oct 6th, 1917.

20-UNDERTAKER. John F Cowan Jr. ADDRESS 901 Holland St

Spec.—8-24-14—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9017

CERTIFICATE OF DEATH.

104 D 9017

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Scott ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary I. E. Lewis

(Residence in Baltimore: No. 622 Scott St.; 1yr. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, April 30, 1917 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
0 yrs. 5 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John W. Lewis

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Katie D. Silverstein

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie D. Lewis

(Address) 622 Scott St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Oct 4 1917, that I saw him alive on Oct 4 1917, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Indigestible food

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Shepherd Brown M. D.

Oct 5, 1917 (Address) 1227 Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Oct 6....., 1917

20-UNDERTAKER	ADDRESS
M + Mrs John A Tenfelde	501 W. Fayette

OCT 5 - 1917

ROBERT R. KRANTZ

Spec.—8-24-14—M. & T.—2000 Bks.

9013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9013

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Frederick

(Residence in Baltimore: No. 1101 W. Lanvale St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. (Month) 16 (Day), 1838 (Year)

7-AGE, 78 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 068
(b) General nature of industry, business, or establishment in which employed (or employer): Schoolteacher

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Lawrence Frederick

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eliza Nussear

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances S. Brown

(Address) 1101 W. Lanvale

15-

OCT 5- 1917 ROBERT R. KRAMER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 6 1917, that I saw her alive on Oct 5 1917, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 5 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. T. Kemp M. D.

Oct 6, 1917. (Address) St. James Apartments

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Oct. 6, 1917

20-UNDERTAKER G. F. Walker — ADDRESS 723 Lafayette Ave

D 9019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9019

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1409 Cooksie St. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Juneck.

(Residence in Baltimore: No. 1409 Cooksie St. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married.

6-DATE OF BIRTH: Do not know. (Month), 1 (Day), (Year)

7-AGE: 66 yrs. – mos. – ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 043 040

9-BIRTHPLACE, (State or Country): Austria.

PARENTS.

10-NAME OF FATHER: Do not know.

11-BIRTHPLACE OF FATHER (State or Country): Do not know.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Anton J. Cesil. (step-son)
(Informant)
(Address) 1409 Cooksie St.

15-
Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October, 4th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct. 5, 1917. (Address) 3017 St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross R C Cem. DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER W. J. Flynn ADDRESS 1422 Light St

OCT 5 1917 ROBERT E. KRAFFT Serial Number

important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9020

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Hollins ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma F. Hepding

(Residence in Baltimore: No. 1313 Hollins St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-(SINGLE) MARRIED, WIDOW(ER) OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 1, 1863 (Month) (Day) (Year)

7-AGE, 54 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Hagerstown Maryland

PARENTS.

10-NAME OF FATHER, John H. Smith

11-BIRTHPLACE OF FATHER (State or Country), Moorefield West Va.

12-MAIDEN NAME OF MOTHER Fannie Griffe

13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John. Hepding

(Address) 1313 Hollins St.

15-

Filed....., 191.....

Registrar.

ROBERT R. KRANTZ

OCT 5 - 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Oct 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Intra Nephritis;
Complicated with Cardiac Debilitie

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

(Signed) F. Nataniew M. D.

Oct 5, 1917 (Address) 901 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, 10-6, 1917.

20-UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins. Sts.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9021

CERTIFICATE OF DEATH.

D 9021

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S. Exeter ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Spinga

(Residence in Baltimore: No. 406 S. Exeter St.; ....yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. (Month) 5 (Day) 1917 (Year)

7-AGE, — yrs. — mos. — ds. If LESS than 1 day, 7 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Anthony Spinga

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Rose Marino

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Marino

(Address) 931 Eastern Ave.

15- OCT 5 1917 ROBERT E. CHARTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 191 , to Oct 5 191 , that I saw h[illegible] alive on Oct 5 191 , and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

1 month Pneumonia

Acute Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph L. Valentine M. D.

Oct 5, 1917. (Address) 131 So. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER Wendell Oppelsson — ADDRESS 37 8th

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9022

CERTIFICATE OF DEATH.

REGISTERED NO. C D 9022

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Tenaglia Tenaglia

(Residence in Baltimore: No. 637 S. Decker Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 14, 1901. (Month) (Day) (Year)

7-AGE, 16 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Alphonsus Tenaglia

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Dominica Marino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alphonsus Tenaglia

(Address) 637 S. Decker ave

15-

Filed ....., 191.... Registrar.

OCT 5 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Oct 5 1917, that I saw h.r alive on Oct 5 1917, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) 10 days

(Duration) ....yrs. ....mos. 7 ds.

(Signed) H. McKerel M. D.

Oct 5, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. ....ds. In the State 17 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 637 S Decker Ave

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct 8, 1917.

20-UNDERTAKER Wendell Coffield — ADDRESS 3?? ??

Spec.—8-24-14—M. & T.—2000 Bks.

D 9023 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 9023

CERTIFICATE OF DEATH. 189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.; ..... WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henderson

(Residence in Baltimore: No. 1840 N. Duncan St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH. Oct 4, 1916. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER, John Henderson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Lyons

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Henderson

(Address) 1834 N. Duncan St

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2 1917, to Oct 4 1917, that I saw him alive on Oct 4 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

.....

Malnutrition

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

(Signed) Bern. Joffe M. D.

Oct 4, 191.. (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1840 N. Duncan St.

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cemetery — DATE OF BURIAL. Oct 6/17, 191...

20-UNDERTAKER Christian Miller — ADDRESS 2534 Jefferson St

OCT 5- 1917 ROBERT B. KRABTEE Registrar of Burial Permits

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9021

CERTIFICATE OF DEATH.

79 D 9021

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2122 Greenmont ave St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. L. Wall

(Residence in Baltimore: No. 2122 Greenmont ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)~~ Mar

6-DATE OF BIRTH, April (Month) 10 (Day), 1858 (Year)

7-AGE, 59 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Richard Wall

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Walsh

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ellen Wall

(Address) 2122 Greenmont ave

15-

Filed OCT 5 1917, 191.... ROBERT R. KRAUSER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep. 20 1917, to Oct 4 1917, that I saw him alive on Oct 3rd 1917, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)
+ Asthenia 5 Cleroses

(Duration) 6 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Thrombus

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Wm M Wright M. D.

Oct 5th, 191 7 (Address) 1704 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER F. a Krause — ADDRESS 703 Hanover

Spec.—5-24-14—M. & Y.—3000 lots.

D 9025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9025

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3433 Greenmount Ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Shipley

(Residence in Baltimore: No. 3433 Greenmount Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Apr 4 (Month) (Day), 1838 (Year)

7-AGE, 79 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Shipley

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Anna Doran

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Shipley

(Address) 3433 Greenmount Ave

15- OCT 6- 1917 HARRY D. ANDREWS Burial Permit Clerk

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 4 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191 5, to Oct 4 1917, that I saw h alive on Oct 4 1917, and that death occurred, on the date stated above, at 11 8 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. ds.

(Signed) James M Boulan M. D.

Oct 6, 191 7 (Address) 707 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Long Green Balto Co

DATE OF BURIAL, Oct 8, 191...

20-UNDERTAKER W. H. Cook

ADDRESS 702 E Northern

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

9026 D 9026

REGISTERED No. C 47

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Penn ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth L. F. Lang

(Residence in Baltimore: No. 213 Penn St.; 7 yrs. 1 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Sing G.

6-DATE OF BIRTH: Sept 2 (Month) (Day), 1910 (Year)

7-AGE: 7 yrs. 1 mos. 2 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balt Md

PARENTS

10-NAME OF FATHER: George Lang

11-BIRTHPLACE OF FATHER (State or country): Balt Md

12-MAIDEN NAME OF MOTHER: Emma Wellman

13-BIRTHPLACE OF MOTHER (State or country): Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Geo Lang

(Address): 213 Penn St

15-

Filed OCT 6-1917, 191 HARRY C. ARMSTRONG Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 4 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4, 191 7, to, Oct 4 191 7, that I saw her alive on Oct 4 191 7, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Chorea & Rheumatism

(Duration) yrs 1 mos. ds.

Contributory (SECONDARY): Broncho Pneumonia

(Duration) yrs 5 mos. 6 ds.

(Signed) Harry Boyd M. D.

Oct 5, 191 7 [Address] 1 E Chase St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 6. 191 7

20-UNDERTAKER: Geo Lewis Bachrach

ADDRESS: 647 N Gay St

TION is very important. See instructions on back

D 9027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9027

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Fallsway [illegible] REGISTERED No. C 169

CITY OF BALTIMORE (No. ~~[illegible]~~ 1618 Eastern av ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Konal Alex

(Residence in Baltimore: No. 1014 Eastern av St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Nov 3, 1910
(Month) (Day) (Year)

7-AGE, 6 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John Alex

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Hilda Kosyn Kalen

13-BIRTHPLACE OF MOTHER (State or Country) Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Alex

(Address) 1014 Eastern av

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 4, 1917 (Address) 610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER Mrs Frankowski — ADDRESS 1618 Eastern Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9028

CERTIFICATE OF DEATH.

105

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214½ Penna Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida B. Ryan

(Residence in Baltimore: No. 1314½ Penna ave St.: 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, April 29th (Month) (Day), 1876 (Year)

7-AGE, 41 yrs. 5 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Gerding

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Hopkins

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman F. Ball

(Address) 1214½ Penna Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 19th 1917, to Oct 4th 1917, that I saw h[er] alive on Oct 3rd 1917, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Enterocolitis

(Duration) ..... yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul Brown M. D.

Oct. 4th, 191... (Address) 183 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount	Oct 6, 191...

20-UNDERTAKER	ADDRESS
H. Sindel & Son	106 Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9029

CERTIFICATE OF DEATH.

21 D 9029

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 550 Fremont ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Washington

(Residence in Baltimore: No. 550 Fremont St.; 44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown ....., 1873
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Washington

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Washington

(Address) 640 Joseph Lee St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct ..... 1917, that I saw h[illegible] alive on Oct 3rd 1917, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... Tuberculosis of the Lungs

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) ... Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) Frank R. Gorman M. D.

Oct 6, 1917. (Address) Frank R. Gorman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Oct 6, 191.

20-UNDERTAKER Samuel Handley

ADDRESS 5 Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9030

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 953 N Washington ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Kovar

(Residence in Baltimore: No. 953 N Washington St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Not Known ....., 1 .....
(Month) (Day) (Year)

7-AGE. 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Feter

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Kovar

(Address) 953 N Washington

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1917, to Oct 3 1917, that I saw h alive on Oct 3 1917, and that death occurred, on the date stated above, at 7 40P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Nephritis (Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Oct. 6, 1917.
20-UNDERTAKER	**ADDRESS**
Frank Cook Son	Fulton Ave

D 9031

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 D 9031

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 934 Woodyear ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilary Elizabeth Holt

(Residence in Baltimore: No. 934 Woodyear St.: ... yrs. 1 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: Aug 30, 1917 (Month) (Day) (Year)

7-AGE: ... yrs. 1 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto.

PARENTS

10-NAME OF FATHER: Thomas Holly

11-BIRTHPLACE OF FATHER (State or country): St. Marys Co

12-MAIDEN NAME OF MOTHER: Sassie Holt

13-BIRTHPLACE OF MOTHER (State or country): St Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sussie Holt

(Address) 934 woodyear st

15.

Filed ..., 191... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 5, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1917, to —, 1917, that I saw h~~e~~ alive on Oct 2, 1917, and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ... yrs. ... mos. 14 ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John [illegible] M. D.

Oct 5, 1917 (Address) 828 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peter cemtery

DATE OF BURIAL: Oct 6, 1917

20-UNDERTAKER: James H. Dennis

ADDRESS: 1303 Preston

state CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9032

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Armstrong

(Residence in Baltimore: No. 2213 Ashland Ave. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (*Write* the word.) married

6-DATE OF BIRTH, Sept 5 1884
(Month) (Day) (Year)

7-AGE, 33 yrs. — mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 14 083

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas H. Armstrong

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emma Kuhnmes

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Pfeiffer

(Address) Johns Hopkins Hosp

15-

OCT 6 - 1917

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Oct 4 1917, that I saw him alive on Oct 4 1917, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

.....

.....

..... (Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Typhoid perforation

Operation (Duration) yrs. mos. 9 ds.

(Signed) Mont R. Reed M. D.

Oct 4, 1917 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State yrs. 1 mos. ds.

Where was disease contracted, if not at place of death? L

Former or usual residence 2013 Ashland Ave.

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem

DATE OF BURIAL, Oct 7, 1917.

20-UNDERTAKER John H. Furst & Co

ADDRESS 200 N. Eutaw

Spec.—5-19-13—M. & T.—500 Bks.

D 9033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130 D 9033

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2343 Eastern Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Boehm

(Residence in Baltimore: No. 2343 Eastern Ave St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October 1, 1875
(Month) (Day) (Year)

7-AGE, 41 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bartender
(b) General nature of industry, business, or establishment in which employed (or employer): 047

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John G Boehm

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER Elizabeth Katzenmyer

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Henry Boehm

(Address) 2343 Eastern Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 191 , to Oct 5 191 ,
that I saw h alive on Oct 4 191 ,
and that death occurred, on the date stated above, at 8:15 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) Geo D Bunce M. D.

Oct 6, 191 (Address) 2815 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Louis Heemann. DATE OF BURIAL, Oct. 5, 191 7.

20-UNDERTAKER Oak Lawn Cemetery ADDRESS 3 C's Road

Spec.—8-24-14—M. & T.—2000 Bks.

D 9031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9031

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2130 E. Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Sommer

(Residence in Baltimore: No. 2130 E. Federal St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June 16th, 1844 (Month) (Day) (Year)

7-AGE, 73 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Housework (037)

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Paulus

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sommer

(Address) 2130 E. Federal

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1917, to Oct. 4th, 1917, that I saw h e alive on Oct 4th, 1917, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

.....

.....

..... (Duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilitation Heart

..... (Duration) ... yrs. 5 mos. ... ds.

(Signed) Albert C Feustel M. D.

Oct 4, 191.. (Address) 1419 E Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Oct. 6, 1917

20-UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

D 9035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9035

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Light ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah C North

(Residence in Baltimore: No. 1304 Light St.: 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 2 (Day), 1848 (Year)

7-AGE, 68 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Phillips

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. Talbot

(Address) 1304 Light St.

15-

OCT 6- 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1916, to Oct 3 1917, that I saw her alive on Oct 3 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

a.....

Carcinoma of Liver

b.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Cancer

..... (Duration).....yrs.....mos.....ds.

(Signed) Wm Lester Taylor M. D.

10-5-, 191.7. (Address) 1304 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Cem Lovely Lane DATE OF BURIAL, Oct 6, 1917

20-UNDERTAKER J. F. Bailey & Son ADDRESS 31 N Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D 9036

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelina Bosica.

(Residence in Baltimore: No. 18 S. Allemande St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. August (Month) 23 (Day), 1916. (Year)

7-AGE. 1 yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 000 .....

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Bosica

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Julia Malmucaia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Bielfa

(Address) Johns Hopkins Hosp

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 5 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 21 191 7 to Oct 5 191 7, that I saw h-er alive on Oct 5 191 7 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

..... Laryngitis acute .....

.....

.....

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) ..... Broncho pneumonia .....

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Henry B. Conrad M. D.

Oct. 5, 191 7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 18 S. Allemande St.

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, ... Oct ....., 191...

20-UNDERTAKER George J. Rieth

ADDRESS 1735 Hanford Ave.

D 9037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 4 + 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Cook

(Residence in Baltimore: No. Sykesville Md St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 1, 1882 (Month) (Day) (Year)

7-AGE, 35 yrs. 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Brakesman (b) General nature of industry, business, or establishment in which employed (or employer) R R Work

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Cook

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Dixon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. C. Gist

(Address) Sykesville Md

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull, Caused by falling off Freight Car of B & O. R.R. (Accidental) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. D. Driscoll M. D.

(Coroner)

Oct 6, 191.7 (Address) 312 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL, Sykesville Md. DATE OF BURIAL, Oct 7, 1917

20-UNDERTAKER, Geo. R. Weer ADDRESS Sykesville Md Sykesville Md.

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 34

D 9033

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Eastern Ave. & Madison ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Chambers

(Residence in Baltimore: No. In Hospital St.; — yrs., — mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Unknown ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 49 yrs. — mos. — ds.

If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dk

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William C. Chambers

(Address) Centreville Md.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6, 1917.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept. 26 1917, to Oct. 6 1917, that I saw him alive on Oct. 6 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation.

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Renal Tuberculosis Indefinite

(Duration) — yrs. — mos. — ds.

(Signed) J. H. D. Peters M. D.

10-6, 1917. (Address) Phil. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 10 ds. In the State 49 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Centreville Md.

19-PLACE OF BURIAL OR REMOVAL. Centreville Md. DATE OF BURIAL, Oct. 6, 1917.

20-UNDERTAKER W. J. Tuthery ADDRESS North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9039 D 9039

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Marie Little

(Residence in Baltimore: No. Westminster Md St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Aug. 26, 1876 (Month) (Day) (Year)

7-AGE. 61 yrs. 1 mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Christian Royer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Young

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Little

(Address) Westminster Md

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5 1917, to Oct 6 1917, that I saw her alive on Oct 6 1917, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

..... (Duration) approximately 1 yrs. 10 mos. 2 ds.

CONTRIBUTORY (Secondary) Post Operative Shock

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Hallie E. Clark M. D.

Oct. 6, 1917. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Westminster Md

DATE OF BURIAL. Oct 6, 1917

20-UNDERTAKER. W M Routson

ADDRESS 230 Greene

Spec.—8-24-14—M, & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9040 D 9040

CERTIFICATE OF DEATH.

REGISTERED NO. C 26

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B Adams Jr

(Residence in Baltimore: No. 3809 Chatham Rd ST. Forest Park yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 15 (Day), 1915 (Year)

7-AGE, 2 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John B Adams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louise Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Charleston S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William B Adams

(Address) 3809 Chatham Rd

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3. 1917, to Oct 5- 1917, that I saw him alive on Oct 5- 1917, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Margaret Tyler M. D.

Oct 5, 191.7. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the State 2 yrs 4 mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Oct 8, 191.7
20-UNDERTAKER George J Smith	ADDRESS 1900 N. Eutaw St.

OCT 6 1917

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9041

CERTIFICATE OF DEATH.

28 D 9041

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Vincent ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dennis Harrison

(Residence in Baltimore: No. 907 Vincent St.; ..... yrs., 2 mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 4 (Day), 1860 (Year)

7-AGE, 57 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 074
(b) General nature of industry, business, or establishment in which employed (or employer): Loading Ships.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Freeman Harrison

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Holly

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Birdie Harrison

(Address) 1023 Argyle Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct 4 1917, that I saw him alive on Oct 4 1917, and that death occurred, on the date stated above, at 5:55 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John C. Stewart M. D.

Oct 10, 191 7 (Address) 1023 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

Baltimore Md

19-PLACE OF BURIAL OR REMOVAL: Prince George County

DATE OF BURIAL: Oct 7th 1917

20-UNDERTAKER: Sam W. Chase-son

ADDRESS: 1400 Mosher st

D 9042 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 305 S Eden St ✗ 3 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mark Wagenheim

(Residence in Baltimore: No. 305 S. Eden St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH Unknown ....., 1832
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
85 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... October 4 ....., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial disease

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Henry Byron Russell M. D.
(Coroner.)
Oct 5, 1917 (Address) 1610 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	10/7, 1917
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

Important. See instructions on back of certificate.

OCT 7 - 1917 ROBERT E. KRAETER Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

D 9043 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9043

CERTIFICATE OF DEATH.

20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1745 E Baltd St ST. V WARD) REGISTERED NO. C

2-FULL NAME Gittle Unorsky

(Residence in Baltimore: No. 1745 E Baltd St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 18 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) 1861 (Year)

7-AGE, 56 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Shea Schotsky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rifka Trosner

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Levis

(Address) 1411 E Balto St

15-

Filed....., 191.....

OCT 7 - 1917 ROBERT B. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 5th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 1917, to Oct. 5th 1917, that I saw h[illegible] alive on Oct. 5th 1917, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Abscess resulting in Septicemia over

(Duration) 7 Weeks yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. L. Hellman M. D.

Oct 6th, 191.. (Address) 17 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel Rd — DATE OF BURIAL, 7/10/17

20-UNDERTAKER Jack Levis — ADDRESS 711 E Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

D. 9044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Riddle.

(Residence in Baltimore: No. University Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 9 (Month) 27 (Day), 1917 (Year)

7-AGE, 0 yrs. 0 mos. 9 ds.

If LESS than 1 day, ...hrs. or 8 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Abraham Riddle

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rosa Chapkin

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa

(Address) 411 E Balto St

15-

OCT 7- 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 6 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 9-27 1917, to 10-6 1917, that I saw h.. alive on 10-6 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

a. Congenital Malformation

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) yrs. mos. ds.

(Signed) I. C. Wood M. D.

Oct 6, 1917 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Workmen circle Mt Carmel

DATE OF BURIAL, Oct 8 191..

20-UNDERTAKER Jack Levin

ADDRESS 411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9015

CERTIFICATE OF DEATH.

91 D 9015

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Ellwood ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin Mateer

(Residence in Baltimore: No. 2438 Ellwood St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 26, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Glenn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Cada Mateer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cada Mateer

(Address) 2438 Ellwood St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/26 1917, to 10/6 1917, that I saw him alive on 10/6 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

a. Bronchopneumonia

b. Bronchopneumonia

Primary

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ....yrs. ....mos. ....ds.

(Signed) B. Bartholow M. D.

10/6, 191.7 (Address) 2438 Ellwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct 7, 191.7

20-UNDERTAKER Samuel Hemsley — ADDRESS 518 W Biddle

OCT 7 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

Lizzie Pritchett

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9046

CERTIFICATE OF DEATH.

38

D 9046

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Pritchett

(Residence in Baltimore: No. 1230 Ashland Ave St.: 42 yrs., 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, October 22nd, 1874
(Month) (Day) (Year)

7-AGE, 42 yrs. 11 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Adam S. Mueller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Keil

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo. Voelker

(Address) 1002 Somerset St

15-

Filed....., 191.....
Registrar.

OCT 7-1917 ROBERT P. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1917, to Oct 5 1917, that I saw her alive on Oct 5 1917, and that death occurred, on the date stated above, at 10,45 m.

The CAUSE OF DEATH* was as follows:

Pyaemia

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Endo-Vesico Fabrics

(Duration) yrs. 1 mos. 4 ds.

(Signed) Lowell M. Riegel M. D.

Oct 6, 1917. (Address) St Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 1 mos. ... ds. In the State 17 yrs. 1 mos. ... ds.

Where was disease contracted, if not at place of death? 1230 Ashland Ave

Former or usual residence 1230 Ashland Ave

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery. DATE OF BURIAL, Oct 8, 1917

20-UNDERTAKER Henry Storck & Son ADDRESS 1304 E Eager St

Important. See instructions on back.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9047

CERTIFICATE OF DEATH.

79

D 9047

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1337 Mosher St. ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary E. Drake

(Residence in Baltimore: No. 1337 Mosher St. St.: 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) 22 (Day) ....., 1844 (Year)

7-AGE, 72 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Gray

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nancy Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rebecca Brown

(Address) 227 Mosher St.

15-

Filed ....., 191.....

Registrar.

OCT 7 - 1917 ROY[illegible] T. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1917, to Oct. 5, 1917, that I saw her alive on Oct. 5, 1917 and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
arteriosclerosis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY .....
(Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct. 7, 1917 (Address) 1706 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Baltimore Md. DATE OF BURIAL, Oct. 8, 1917

20-UNDERTAKER, Smith & Englebrecht ADDRESS 2132 N. Howard St.

Important. See instructions.

D 9048

HEALTH DEPARTMENT—CITY OF BALTIMORE

36

CERTIFICATE OF DEATH.

D 9048

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Mayland Gel Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence P. Kennerly

(Residence in Baltimore: No. 1714 North Charles Street St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Nov (Month) 2 (Day) 1902 (Year)

7-AGE, 14 yrs. 10 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Mayland

PARENTS.

10-NAME OF FATHER, Walter Kennerly

11-BIRTHPLACE OF FATHER (State or Country) Mayland

12-MAIDEN NAME OF MOTHER Edna Phillips

13-BIRTHPLACE OF MOTHER (State or Country) Mayland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Kennerly

(Address) 1714 N. Charles

15-

Filed....., 191.....

OCT 7 - 1917 ROBERT B. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Pneumonia

(Duration) yrs. mos. ds.

Signed) C. W. Wallace M. D.
(Coroner)

Oct. 6, 1917 (Address) 1911 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Oct. 8, 1917

20-UNDERTAKER William Cook

ADDRESS 507 E. Nash

Circular of information. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 9049

CERTIFICATE OF DEATH

105 D 9049

1-PLACE OF DEATH Robert Garrett Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 27 North Leary ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Bennett

(Residence in Baltimore: No. 1107 Myrtle ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: June (Month) 29 (Day), 1915 (Year)

7-AGE: 2 yrs. 3 mos. 8 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto md.

PARENTS

10-NAME OF FATHER: Marion Bennett

11-BIRTHPLACE OF FATHER (State or country): Balto md.

12-MAIDEN NAME OF MOTHER: Anna Gruber

13-BIRTHPLACE OF MOTHER (State or country): Balto md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Bennett

(Address) 1107 Myrtle Ave

15-

Filed ....., 191.... REGISTRAR

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1, 1917, to, October 6 1917, that I saw him alive on October 5 1917, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) — yrs — mos 16 ds.

Contributory (SECONDARY) none

(Duration) ... yrs ... mos. ... ds.

(Signed) Thos Cook M. D.

Oct 6, 1917 [Address] 27 N. Leary St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 6 ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Bl

DATE OF BURIAL: Oct 8, 1917

20-UNDERTAKER: Wm Cook

ADDRESS: 502 E North Av.

OCT 7 1917 ROBERT B. KRAETER

D 9050

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 D 9050

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 658 N. Saratoga St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salome Jamdauckas

(Residence in Baltimore: No. 658 N. Saratoga St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: no (Month), (Day), 1867 (Year)

7-AGE: 50 yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): — 037

9-BIRTHPLACE (State or country): Lithuania

PARENTS

10-NAME OF FATHER: Raffel Tamasauckas

11-BIRTHPLACE OF FATHER (State or country): Lithuania

12-MAIDEN NAME OF MOTHER: no

13-BIRTHPLACE OF MOTHER (State or country): no

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Grebliauckas

(Address) 425 So Paca St

15- Filed ..... 191..... REGISTRAR

OCT 7 - 1917 ROBERT R. KRAMER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 5 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug. 9, 1917, to Oct. 5 1917, that I saw her alive on Oct. 4 1917, and that death occurred, on the date stated above, at 5 07 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 3 yrs mos. ds.

Contributory (SECONDARY) Chr. Interstitial Nephritis

(Duration) 2 yrs mos. ds.

(Signed) John A. Krakowsky M. D.

Oct. 5, 1917 [Address] 629 Baltimore Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 658 N Saratoga St

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Oct 8, 1917

20-UNDERTAKER: John Grebliauckas — ADDRESS: 425. S. Paca St

TION is very important. See instructions on

D 9052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9052

CERTIFICATE OF DEATH.

175

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Mary & Hospital St. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August W Volk.

(Residence in Baltimore: No. 2026 E Lombard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Oct 7, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. 11 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor 086
(b) General nature of industry, business, or establishment in which employed (or employer): Smith

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas Volk.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Theresa Budeger

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Volk

(Address) 2026 E Lombard

15-

OCT 7 1917

Filed ....., 191.... ROBERT B. KRAETER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
Auricular Fibrillation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Grant Jaquett M. D.
(Coroner)

Oct 6 191 7 (Address) 4 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	October 9 1917.
20-UNDERTAKER	ADDRESS
Wendell Wippell & Son	57 S Amm

important. See instructions on back of certificate.

D 9052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9052
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1136 North St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vodka Hawkins

(Residence in Baltimore: No. 1136 North St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, June 25, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 3 mos. 19 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Judge Hawkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Victoria Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1136 North

15-

Filed....., 191....
Registrar.

CAUSE OF DEATH. Information required is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus Traumatic

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Infected Wound

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

....., 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State.... yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 7, 1917

20-UNDERTAKER Harman & Wright — ADDRESS 364 W Cary

Rep M. Gorcon.

F 9053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9053

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fenton & Lanvale St.) ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rep M Gorcon

(Residence in Baltimore: No. 1807 Lanvale Lamon St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col	Single

6-DATE OF BIRTH, July 19, 1906
(Month) (Day) (Year)

7-AGE, 11 yrs. 2 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John McGorcon

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sarah Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1809 Lanvale

15-

Filed....., 191.....

Registrar.

ROBERT R. KRAUTER
OCT 24 1917
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Killed by Auto

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Fractures

(Duration).....yrs.....mos.....ds.

(Signed) H. Mitchell Lee M. D.
(Coroner)

....., 191.. (Address) 918 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Gaithersburg Md.	Oct. 18, 1917
20-UNDERTAKER	ADDRESS
James H. Dennis	1302 Pennsylvania

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9051

CERTIFICATE OF DEATH.

109

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital, St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss. Beasie Creighton

(Residence in Baltimore: No. 518 Garrison Lane St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Dec 23 (Month) (Day) 1890 (Year)

7-AGE 26 yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Store Department
(b) General nature of industry, business, or establishment in which employed (or employer): Clerk 009

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. W. Creighton

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sophronia Blackburn

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophronia Blackburn

(Address) 518 Garrison Lane.

15-

OCT 7- 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4 191 7, to Oct 6 191 7, that I saw h alive on Oct 6 191 7, and that death occurred, on the date stated above, at 3.15 Am.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

& cancer of gut (Duration) yrs. mos. 4 ds.

(Signed) Frank C. Irwin M. D.

Oct 6, 191 7 (Address) Mine Hap

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2.

Former or usual residence 518 Garrison Lane

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Oct 9, 191 7

20-UNDERTAKER Wm. E. Evans Sons — ADDRESS 1425 N. Charles St

18

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9055

CERTIFICATE OF DEATH.

43 D 9055

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Linwood Parkway ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Isabelle Lauman

(Residence in Baltimore: No. 807 Linwood Parkway St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, June 10, 1863
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 2 mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Mason.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Sudry

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jessie Mason

(Address) 807 Linwood Parkway

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jul 2 1917, to Oct 6 1917, that I saw h[illegible] alive on Oct 5 1917, and that death occurred, on the date stated above, at 5-10 a m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....Carcinoma of the breast

..... (Duration)....1....yrs. 0....mos. 0....ds.

CONTRIBUTORY Metastases in stomach
(Secondary)
and liver (Duration)....yrs. 3 mos. ....ds.

(Signed)....Julius Friedman M. D.

Oct. 6, 1917 (Address) 10 13st Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Oct. 9, 1917
20-UNDERTAKER	ADDRESS
Albert E. Fuller	22[illegible] Broadway

OCT 7 1917 ROBERT R. KRAUTER
Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

D 9056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9056

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3357 Chestnut ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Dunn

(Residence in Baltimore: No. 3357 Chestnut St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 28, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, William Dunn

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catherine Kenny

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cath. Dunn

(Address) 3357 Chestnut

15-

Filed....., 191.....
Registrar.

OCT 7 - 1917 ROBERT R. KRAETER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 4th 1917, to October 6th 1917, that I saw her alive on October 5 1917, and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Acute Ulc. Colitis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Brown M. D.

Oct. 6, 1917. (Address) 2014 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Oct. 8, 1917

20-UNDERTAKER John A. Mann

ADDRESS 2000 E Balto St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9057 — + 92 — D 9057

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Da Costa

(Residence in Baltimore: No. 810 J. St. Shannon Pl St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Widower

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 52 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 040 .....

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Cuban

12-MAIDEN NAME OF MOTHER Cuban

13-BIRTHPLACE OF MOTHER (State or Country), Cuban

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Pheiffer

(Address) John Hopkins Hosp.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1917, to Oct. 5 1917, that I saw him alive on Oct. 5 1917, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Wells M. D.

Oct. 5, 1917 (Address) John Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 810 J. St. Shannon Pl

19-PLACE OF BURIAL OR REMOVAL, Arbarry Cemetery — DATE OF BURIAL, October 9, 1917

20-UNDERTAKER Felix B. Frye — ADDRESS 102 E. Mulberry St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9058

CERTIFICATE OF DEATH.

15 D 9058

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Fleet ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav Winkler

(Residence in Baltimore: No. 2212 Fleet St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 7, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 9 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Chas Winkler

11-BIRTHPLACE OF FATHER (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Lena Leimbach

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Chas Winkler

(Address)..... 2212 Fleet St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7 1917, to ....191...., that I saw h[illegible] alive on Oct. 7 1917, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 mos)

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) Edwin S. Neff M. D.

10/8, 191... (Address) 1405 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
5th Reformed	Oct. 8..., 1917
20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9059

CERTIFICATE OF DEATH.

92 D 9059

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Mount ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelone M. Foggetti

(Residence in Baltimore: No. 718 N. Mount St St.; 66 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 21 (Day), 1843 (Year)

7-AGE, 74 yrs. 2 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Confectioner
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Foggetti

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Foggetti

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angelone A Foggetti Jr

(Address) 718 N. Mount St

15-

Filed ....., 191.....

OCT 8- 1917 ROBERT R. KRAFTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 6 1917, that I saw him alive on Oct 6 1917, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza & Sepsis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) F. Nitarini M. D.

Oct 7, 1917. (Address) 901 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery C.A. Co

DATE OF BURIAL, Oct 7, 1917

20-UNDERTAKER G. H. Smith M.D.

ADDRESS 1000 Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9060

CERTIFICATE OF DEATH.

78 ✓

1-PLACE OF DEATH

REGISTERED NO. C 9060

CITY OF BALTIMORE: (No. 933 N. Mount ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Joseph E. Medling

(Residence in Baltimore: No. 933 N. Mount St.; 16 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, September 1st, 1861
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
56 yrs. 1 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Minister of
(b) General nature of industry, business, or establishment in which employed (or employer): the Gospel 018

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, ? Medling

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Caroline Nolle

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Fannie Medling

(Address) 933 N. Mount St.

15-

Filed ....., 191.... Registrar.

OCT 8- 1917 ROBERT R. KRAETER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1917, to Oct 7 1917, that I saw him alive on Oct 7 1917, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Myocarditis

(Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) M Bowman Lloyd M. D.

Oct 7, 1917. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Oct 9th, 1917

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9061

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 N. Carrist ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Stewart

(Residence in Baltimore: No. 302 N. Carrist St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 60 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hand 041
(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Robert Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Annie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stella Stewart

(Address) 302 Parrish St

15-

Filed ....., 191.....

OCT 8- 1917 ROBERT B. KRAUTH
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 5 1917, that I saw her alive on Oct 5 1917 and that death occurred, on the date stated above, at 10.20 m.

The CAUSE OF DEATH* was as follows:

Intestinal Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. B. Bradford M. D.

1916, 1917 (Address) 1521 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dawes Gardens — DATE OF BURIAL, Oct 7, 1917

20-UNDERTAKER Charles B. Jones — ADDRESS 835 Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9062

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1020 Valley ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Colleran

(Residence in Baltimore: No. 1020 Valley St.; 54 yrs., \ mos., \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Not Known ....., 1 ..... (Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, M. Gaynor

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Colleran

(Address) 1020 Valley St

15-

Filed..... 191.....

Registrar.

OCT 8- 1917 ROBERT D. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 7 1917, that I saw h[illegible] alive on Oct 5 1917, and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septic intoxication

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) James M. Kenton M. D.

Oct 7, 191 7 (Address) 707 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, Oct 10, 191 7.

20-UNDERTAKER Henry Hoerle & Son

ADDRESS 1301 E Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9063

CERTIFICATE OF DEATH.

108 ✓ D 9063

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimoremm Gen. Hospital ST. 32 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly May Merrick

(Residence in Baltimore: No. 2857 Prospect St.: 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 27, 1865.
(Month) (Day) (Year)

7-AGE, 42 yrs. — mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. A. Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Kate Morecan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Katie Smith

(Address) 2117 Hollins St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 5 1917, to October 6 1917, that I saw her alive on October 6 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured appendicular Abscess (Duration) — yrs. — mos. 3 ds.

(Signed) Charles E. Clark M. D.

October 6 1917. (Address) 1310 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 2857 Prospect St

Former or usual residence 2857 Prospect St

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Oct 8..., 1917

20-UNDERTAKER H M Routson

ADDRESS 230 N. Gay

D 9064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9064

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 816 Ostend ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard A Garrett

(Residence in Baltimore: No. 816 Ostend St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 8 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Garrett

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Florence Hammond

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Garrett

(Address) 816 Ostend St

15-

Filed....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h! death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Enteritis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Improper Feeding

(Duration) ....yrs. ....mos. 28 ds.

(Signed) James M Denton M. D. (Coroner.)

Oct 6, 191 7 (Address) 1 W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 8 1917

20-UNDERTAKER Wilbur Brown

ADDRESS 905 Hollins St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 ✓ D 9065

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Bank St ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angeline Lambeck

(Residence in Baltimore: No. 1800 Bank St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Male~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 13th, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....None....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Lambeck

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ida Jankowski

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Ahern

(Address) 1800 Bank St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Oct 5th 1917, that I saw h[illegible] alive on Oct 6th 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis X Ileo Colitis

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Thos A Mitchell M. D.

Oct 6, 191.7 (Address) 1621 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	Oct 8th 191.7
20-UNDERTAKER John A Ahern	ADDRESS Bank & Ann Sts

OCT 8- 1917 ROBERT P. STARKEY

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9066

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 N. Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. John Gourley

(Residence in Baltimore: No. 1021 N. Gilmor St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ Married (Write the word.)

6-DATE OF BIRTH. Dec. 8, 1842 (Month) (Day) (Year)

7-AGE. 75 yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Tobacconist 645

(b) General nature of industry, business, or establishment in which employed (or employer). retired 10 yrs

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Thomas Gourley

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Maginn

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. A. Gourley

(Address) 1021 N. Gilmor

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1917, to Oct 5 1917, that I saw h[illegible] alive on Oct 5 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Embolism

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. endocarditis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) Homer H. Frost M. D.

Oct 8, 1917. (Address) 735 N. Breton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral

DATE OF BURIAL. Oct 9, 191.

20-UNDERTAKER John Gerwig & Co

ADDRESS 2008 Eutaw

OCT 8 1917 ROBERT B. KRAUTER BURIAL PERMIT

D 9067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9067

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 578 Baker Rist St. 14 WARD) 1.

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Arella Grimes

(Residence in Baltimore: No. 578 Baker Stirt St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Colored	Single

6 DATE OF BIRTH March 24, 1903
(Month) (Day) (Year)

7 AGE 14 yrs. 6 mos. 11 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto md

PARENTS

10 NAME OF FATHER George Grimes

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Sidney Chase

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sidney Chase

(Address) 578 Baker st

15 Filed OCT 8- 1917 ROBERT B. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1917, to. Oct 5 1917, that I saw he alive on Oct 5, 1917, and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows: Pneumonia (D.T.)

(Duration) yrs. mos. 14 ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) yrs. mos. 14 ds.

(Signed) [illegible] M. D.

Oct 7, 1917 (Address) 718 Dia[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Auburn — DATE OF BURIAL Oct 9- 1917

20 UNDERTAKER James H. Dennis — ADDRESS 1303 Pressman

State CAUSE OF DEATH in plain terms. Indefinite answers are worthless. Every question is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99 ✓ D 9068

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Druid Hill Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice L. Jackson

(Residence in Baltimore: No. 1423 Druid Hill Ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) —

6-DATE OF BIRTH, July 31, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Harvey Jackson

11-BIRTHPLACE OF FATHER (State or Country), Lawson Cty Mississippi

12-MAIDEN NAME OF MOTHER Louise Alexander

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Alexander.

(Address) 1423 Druid Hill ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1917, to Oct 6 1917, that I saw h[illegible] alive on 10/6 1917, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

..... (Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) B. Bruce Butler M. D.

10/8, 1917. (Address) 2339 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 8, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Preston

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9069

CERTIFICATE OF DEATH.

92 D 9069

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Dennison ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margarete B Jackson

(Residence in Baltimore: No. 1423 Dennison St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) —

6-DATE OF BIRTH, July 31, 1915.
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Harold Jackson

11-BIRTHPLACE OF FATHER (State or Country), Kansas City Missouri

12-MAIDEN NAME OF MOTHER Louise Alexander

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Alexander

(Address) 1423 Dennison Hillen ave

15-

Filed....., 191.....

Registrar.

OCT 8- 1917

ROBERT R. KRAUTEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 191 7, to Oct 6 191 7, that I saw h.. alive on Oct 6 191 7, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) Burk Bentley M. D.

Oct 8, 191 7 (Address) 1139 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Oct 8, 191 7.

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Preston ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9070 15-2 D 9070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Johns Hopkins Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cook.

(Residence in Baltimore: No..... St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, Oct 2, 1917.
(Month) (Day) (Year)

7-AGE, ✓ yrs. ✓ mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Sidney Baker

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Ella Cook.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- OCT 8- 1917 ROBERT R. CRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 3 1917, that I saw him alive on Oct 3 1917, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Intracranial haemorrhage

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) over

..... (Duration).....yrs.....mos.....ds.

(Signed) John Glenn Jr. M. D.

Oct 3, 1917. (Address) JHH.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, OCT 8 1917, 191...

20-UNDERTAKER Commissioner Health. ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9071

CERTIFICATE OF DEATH.

175 D 9071

1 PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Hudson

(Residence in Baltimore: No. 1405 Anthony St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 5, 1915 (Month) (Day) (Year)

7-AGE, 1 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, John C Hudson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rose B. Kennie

13-BIRTHPLACE OF MOTHER (State or Country), Norfolk Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hudson

(Address) 1405 Anthony St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull & Internal injuries received in automobile smash up (Accidental)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A J Finnell M. D.
(Coroner)

Oct 6, 191. (Address) 312 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS.)
At place of death..... yrs..... mos. 6 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Oct 8, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1522 Light

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

James Brooks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9072

CERTIFICATE OF DEATH.

Registered No. C 58

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Provident Hospital St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Brooks

(Residence in Baltimore: No. 508 N. Eden St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Factory

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Brooks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sallie Causey

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Brooks

(Address) 508 N. Eden

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Exposure to Heat

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Hearn Asst. M. D.
(Coroner)

Oct 8, 1917. (Address) 819 N. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State 5 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 508 N. Eden St.

19-PLACE OF BURIAL OR REMOVAL, Leakey Cemetery DATE OF BURIAL, Oct. 10

20-UNDERTAKER R. O. Gross & Co's ADDRESS McElderry

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9073

HEALTH DEPARTMENT—CITY OF BALTIMORE

137 D 9073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Johns Hopkins Hospital — REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.;..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Frances Hall.

(Residence in Baltimore: No. 507 North Broadford St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female — 4-COLOR OR RACE: Black — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: May — (Month), — (Day), 1875 (Year)

7-AGE: 42 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE, (State or Country): Delaware

PARENTS.

10-NAME OF FATHER: Frank Macey

11-BIRTHPLACE OF FATHER (State or Country): Delaware

12-MAIDEN NAME OF MOTHER: Mary Orrell (?)

13-BIRTHPLACE OF MOTHER (State or Country): Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): John Shearer Jr.

(Address): Johns Hopkins

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: October (Month) 1 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 191 7, to Oct 4 191 7, that I saw her alive on Oct 4 191 7 and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Complicating Pregnancy

(Duration) 1 yr. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage — otic

(Duration) ..... yrs. ..... mos. ½ ds.

(Signed) John Shearer Jr. M. D.

Oct 4, 191 7 (Address) Johns Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 8 ds. — In the State 20 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 507 N. Broadford

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct 6, 191 7

20-UNDERTAKER Harry A Vodary — ADDRESS 1728 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9071 D 9071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.; 2 WARD)

REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Brook

(Residence in Baltimore: No. 25 N. Ann St ; yrs., mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown — , 1873
(Month) (Day) (Year)

7-AGE, 44 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer) 637

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Hyman Schutz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Katie Schutz

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Brook

(Address) Covington Va

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Oct 7 1917,
that I saw her alive on Oct 6 1917,
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) 2 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. 22 ds.

(Signed) A. McGlannahan M. D.

10-7, 1917 (Address) John H. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State yrs. mos. 22 ds.

Where was disease contracted, if not at place of death? Covington Va

Former or usual residence Covington Va

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Friendship

DATE OF BURIAL, Oct. 8, 1917

20-UNDERTAKER Jack Levin

ADDRESS 1411 E. Fayette.

D 9075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9075

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 327 N Fulton ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E Davis

(Residence in Baltimore: No. 327 N Fulton ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, April 10, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. 5 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Secretary 176
(b) General nature of industry, business, or establishment in which employed (or employer): Civil Service, Examiner U.S. 137

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: William E Davis

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Henrietta Smith

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carrie Davis

(Address) 327 N Fulton

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos. 1/2 hr

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) 1 yrs.....mos.....ds.

(Signed) James H Pearson M. D.
(Coroner.)

Oct 6 191 7 (Address) 710 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Boonsboro Md

DATE OF BURIAL: Oct 9, 1917

20-UNDERTAKER: Chas E. Franck

ADDRESS: C.E. Franck

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital WARD) 20

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Katherine Anna Wheeler

(Residence in Baltimore: No. 1845 West Fayette St.; 46 yrs. 9 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Jan. (Month) 4 (Day), 1871 (Year)

7-AGE, 46 yrs. 9 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Weber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaretha Buehler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Wheeler

(Address) 1845 W. Fayette St.

15-

Filed....., 191.....

Registrar.

OCT 8- 1917

ROBERT R. KRAETER
Record Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th 7.30 P.M., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 10 am 1917, to Oct 6 1917, that I saw her alive on Oct 6 1917, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Two weeks

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Farmer Jr. M. D.

Oct. 6, 1917. (Address) Franklin Sq. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Same In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 1845 W Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct. 10, 1917.

20-UNDERTAKER Jos. Jeardens & Son ADDRESS 217 S. Paca

Spec.—8-24-14—M. & T.—2000 Blks.

D 9077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9077

REGISTERED No. C.....

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ~~1312 Eutaw Place~~ ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne Warren Miller

(Residence in Baltimore: No. 1312 Eutaw Place St.; ....yrs., ...mos. 20 mm. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	W.	Single

6-DATE OF BIRTH, Oct. (Month) 8 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. ....ds.	....hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Church Home & Inf.

PARENTS.

10-NAME OF FATHER, Harold Warren

11-BIRTHPLACE OF FATHER (State or Country), Balt Md

12-MAIDEN NAME OF MOTHER Mildred Elizabeth McClayton

13-BIRTHPLACE OF MOTHER (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold W. Miller

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from ~~Oct 8, 1917~~ 755 AM Oct 8, 1917 ~~191~~, to 815 AM Oct 8 1917, that I saw her alive on above date 191, and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Eclampsia g. mother

Symptoms of eclampsia began about 30 minutes before delivery.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Hassenplug M. D.

Oct 8....., 191 7. (Address) Church Home Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 20 mm. yrs. mos. ds. In the State 20 mm. yrs. mos. ds.

Where was disease contracted, if not at place of death? from mother.

Former or usual residence 1312 Eutaw Place.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Balto Cem	Oct 9, 191 7

20-UNDERTAKER	ADDRESS
Wm Cook.	502 E North

Spec.—8-24-14—M. & T.—2000 Bks.

D 9078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 9078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Madison Av ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecilia Simes

(Residence in Baltimore: No. 1723 Madison Ave. St.; 46 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1835
(Month) (Day) (Year)

7-AGE, 82 — — yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Rimes

(Address) 1723 Madison Ave

15-

Filed....., 191.....

Registrar.

OCT 8- 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 6th, 1917.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 1917, to Oct. 6th 1917, that I saw her alive on Oct 6 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Valvular Heart Trouble

(Duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldberg M. D.

10-6..., 1917. (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cem. Washington Road — DATE OF BURIAL, Oct 10, 1917.

20-UNDERTAKER L. Sondheim — ADDRESS 118 Lombard & Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9079 ✓ 64 D 9079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Emersonian Apartments. Eutaw Place, ST.; 13 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Greif.

(Residence in Baltimore: No. Emersonian Apartments, Eutaw Place. Lifetime, St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, December 30, 1865
(Month) (Day) (Year)

7-AGE, 51 yrs. 9 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clothing 045
(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturer,

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Levi Greif

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hennie Fleischman.

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Mr. Leonard Greif.
(Informant).....
Riviera Apartments.
(Address).....

15-
Filed....., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th., 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1917, to Oct 6 1917, that I saw h[illegible] alive on Oct 6 1917, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 7 yrs. ...mos. ...ds.

(Signed) Louis P. Hamburger M. D.

Oct 7, 1917. (Address) 120 E Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Hebrew Cem. DATE OF BURIAL, Oct. 9, 1917

20-UNDERTAKER David Rondheim 118 W. ADDRESS Mt. Royal Ave

D 9080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

REGISTERED NO. C

D 9080

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1) University Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph D. Diamond

(Residence in Baltimore: No. 1011 N. Monroe St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 14, 1865
(Month) (Day) (Year)

7-AGE, 52 yrs. 8 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03 V

200

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William A. Diamond

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary J. Beaty

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Diamond

(Address) 1011 N Monroe St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
2d degree burns Caused by Escaping steam at Consolidated R. L. & Electric Co power house (accidental)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert L. Duvall M. D.
(Coroner.)
Oct 7, 1917 (Address) 312 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?
1011 N Monroe St

Former or usual residence 1011 N Monroe St

19-PLACE OF BURIAL OR REMOVAL, Union Protestant

DATE OF BURIAL, Oct 9, 1917

20-UNDERTAKER, Josiah Depew

ADDRESS 1600 W North Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9081

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Foot of Hayes St. St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Theodore Gunke

(Residence in Baltimore: No. Foot of Hayes St. St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug. 4, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Paul Gunke.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary Kahlein

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Paul Gunke.

(Address) Foot of Hayes St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 8, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1917, to Oct. 8 1917, that I saw h.... alive on Oct. 6. 1917, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY, Malnutrition
(Secondary)

(Duration) ....yrs. 2 mos. ....ds.

(Signed) W. C. Teutinger M. D.

1017 E. Baltimore, 1917, (Address) 962 Columbus Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Louden Park — DATE OF BURIAL. Oct. 10 1917.

20-UNDERTAKER. Josiah Sipper — ADDRESS 1600 N. Gaylord ave

Mad 1685 W.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 D 9082

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William V. Wheeler

(Residence in Baltimore: No. 1013 N. Caroline St St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. 23, 1873
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 7 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Locomotive

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, William Wheeler

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hooper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Conde

(Address) Mercy Hosp.

15-

Filed OCT 8 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Oct 5 1917, that I saw him alive on Oct 5 1917, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

2
Typhoid Fever
11
alm
(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) 0
(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward V. Smith M. D.

Oct 8, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State Do not know yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1013 N. Caroline St.

Former or usual residence 1013 N. Caroline St.

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, Oct. 8, 1917.

20-UNDERTAKER Wm C. Black

ADDRESS 927 N. Broadway

D 9083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

D 9083

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 972 Ft Falls Rd ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny J Hamilton.

(Residence in Baltimore: No. 972 Ft Falls Rd St.; 1 yrs., (mos. (ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 5, 1854 (Month) (Day) (Year)

7-AGE, 63 yrs. mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, Jesse H. Boulden

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Varilla Moore

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse H B Hurst.

(Address) 972 Ft Falls Rd

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Gas Poisoned

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Sum Gas Poisoned

(Duration) ....yrs. ....mos. ....ds.

(Signed) John J Morrissey M. D. (Coroner)

Oct 8, 1917 (Address) 1632 Rolandvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Millersburg Bourbon Co Kentucky

DATE OF BURIAL, Oct 8, 1917.

20-UNDERTAKER Wm Cook

ADDRESS 502 E. North.

Via C & O R R. To Jesse B Hurst.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9081 D 9081

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Altamont Hotel ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almira Lincoln Phelps

(Residence in Baltimore: No. Altamont Hotel St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 31st (Month) (Day), 1834 (Year)

7-AGE, 81 yrs. 8 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Guilford Vt

PARENTS.

10-NAME OF FATHER, John Phelps

11-BIRTHPLACE OF FATHER (State or Country), Vermont

12-MAIDEN NAME OF MOTHER Almira Hart

13-BIRTHPLACE OF MOTHER (State or Country), Connecticut

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Phelps

(Address) 10 E. Fayette St.

15-

Filed OCT 8- 1917, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1916, to Oct 7 1917, that I saw h[er] alive on Oct 7 1917, and that death occurred, on the date stated above, at 7P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

(Signed) James E. Clarke M. D.

Oct 8, 1917 (Address) 1201 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, Oct 10th, 1917

20-UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS McCulloh & Dol

Spec.—8-24-14—M. & T.—2000 Bks.

D 9085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D 9085

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 E. Fayette ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Adams

(Residence in Baltimore: No. 2222 E. Fayette St.; 74 yrs., 8 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb 5, 1843
(Month) (Day) (Year)

7-AGE—	If LESS than 1 day,
74 yrs. 8 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John France

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Adams

(Address) 520 N. Rose St

15-

Filed OCT 8- 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 2 1917, to October 7 1917, that I saw h.. alive on October 7 1917, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchio-pneumonia

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J. Ash M. D.

Oct 8, 1917. (Address) 1963 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cemetery	Oct 10, 1917

20-UNDERTAKER	ADDRESS
Christian Miller	2334 Gough St

Spec.—8-24-14—M. & T.—2000 Bks.

Josephine M Douglass.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9086

CERTIFICATE OF DEATH.

D 9086

1-PLACE OF DEATH 1504 N. Chapel st.

CITY OF BALTIMORE: (No. 1504 N. Chapel st WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine M. Douglass.

(Residence in Baltimore: No. 1504 N. Chapel st St.; ..... yrs., 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Infant.

6-DATE OF BIRTH, June 22, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robert F. Douglass

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Caroline G. Huber.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert F. Douglass

(Address) 1504 N. Chapel.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to October 7 1917, that I saw her alive on October 7 1917, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia (Bronchial)

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Thomas J. Emmert M. D.

Oct 8th, 1917. (Address) 1025 Mc.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys. | DATE OF BURIAL, Oct 9th, 1917.

20-UNDERTAKER Ellenworth & Son. | ADDRESS 360 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 9087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9087

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 Ashland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Carl Fritsch

(Residence in Baltimore: No. 2325 Ashland Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 13 (Day) 1901 (Year)

7-AGE, 16 yrs. 7 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Typesetter
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Fritsch

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Minna Fortius

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Fritsch

(Address) 2325 Ashland

15-

OCT 9- 1917 ROBERT R. KRAUTER REGISTRAR

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Oct 7 1917, that I saw h m alive on Oct 7 1917, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

1 Typhoid fever

(Duration) ..... yrs. ..... mos. 37 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward C Lemmon M. D.

Oct 8, 191.. (Address) 1429 Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balt Cem

DATE OF BURIAL, Oct 9, 191..

20-UNDERTAKER Geo Lew Lackston

ADDRESS 647 N Pac

Spec.—8-24-14—M. & T.—2000 Bks.

D 9088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9088

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Oak St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archie Wyatt

(Residence in Baltimore: No. 2416 Oak St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, Col | 5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1879
(Month) (Day) (Year)

7-AGE, 38 yrs. ....mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Wyatt

(Address) 2416 Oak St

15-

Filed....., 191.....

OCT 9- 1917 ROBERT L. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 7 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 10 1917, to Oct 6 1917, that I saw h[illegible] alive on Oct 6 1917, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis

.....

.....

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. Garland Ober M. D.

....., 191... (Address) 1534 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary | DATE OF BURIAL. Oct. 9....., 1917

20-UNDERTAKER Mrs R A Elliott | ADDRESS 506 East St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9089 — 130 — D 9089

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 St. Joseph ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Distance

(Residence in Baltimore: No. 1605 St. Joseph St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. Sept 2, (Month) (Day) 1898 (Year)

7-AGE. 19 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Girl
(b) General nature of industry, business, or establishment in which employed (or employer). School Girl

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Samuel Distance

11-BIRTHPLACE OF FATHER (State or Country). Baltimore County

12-MAIDEN NAME OF MOTHER. Carrie Young

13-BIRTHPLACE OF MOTHER (State or Country). in Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Carrie Distance

(Address) 1605 St Joseph St

15-

Filed....., 191.....

OCT 9- 1917 ROBERT H. KRAETER

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3 1917, to Oct. 8, 1917, that I saw her alive on Oct. 6, 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Dysentery

.....

.....

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemic Nephritis

..... (Duration) 3 yrs. ....mos. ....ds.

(Signed) C. Keller M. D.

10 8 17, 191.. (Address) 1520 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Laural Cemetary

DATE OF BURIAL. Oct. 10..., 191.7.

20-UNDERTAKER Mrs R. A Elliott

ADDRESS 306 East 24

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9090

CERTIFICATE OF DEATH.

89 ✓

D 9090

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pawel Wegrzenowski

(Residence in Baltimore: No. 329 S. Bond St ST.; ..... yrs., ... mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 20 (Day), 1917 (Year).

7-AGE. ..... yrs. ..... mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Now
(b) General nature of industry, business, or establishment in which employed (or employer): " " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Wegrzenowski

11-BIRTHPLACE OF FATHER (State or Country), Austria Galicia

12-MAIDEN NAME OF MOTHER Mary Swiszko

13-BIRTHPLACE OF MOTHER (State or Country), Austria Galicia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wegrzenowski

(Address) 329 S. Bond St

15-

OCT 9- 1917 ROBERT B. KRAETER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 8 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to Oct 8 1917, that I saw him alive on Oct 8 1917, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Dawnyszyn M. D.

Oct 9, 191.. (Address) 2431 Fait

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct. 9, 191..

20-UNDERTAKER William Fairgrieve

ADDRESS 168 Eastern Ave.

D 9091

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 79 ✓

D 9091

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 825 N. Eutaw ST.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Parsons (Parsons)

(Residence in Baltimore: No. 825 N Eutaw St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6-DATE OF BIRTH Aug. 15 (Month) (Day), 1888 (Year)

7-AGE 29 yrs. 2 mos. 24 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Domestic Duties
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Va

PARENTS

10-NAME OF FATHER Lumber D. Johnson

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Caroline Bloxam

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address) Parksley, Va

15

Filed OCT 9- 1917, 191 ..... Burial Permit Clerk

REGISTRAR

ROBERT B. KRAUER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct 8 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1917, to Oct 8 1917, that I saw h[er] alive on 10 A.M. 1917, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) 48 hrs. mos. ds

Contributory (SECONDARY) Rheumatism

(Duration) yrs. mos. ds.

(Signed) C. Waddington M. D.

Oct 9, 1917 (Address) 802 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 1 wk ds. In the State yrs. mos. 1 wk ds.

Where was disease contracted, if not at place of death? none

Former or usual residence Parksley Va

19-PLACE OF BURIAL OR REMOVAL: Parksley Va — DATE OF BURIAL: Oct 9. 1917

20-UNDERTAKER: C A Franck — ADDRESS: 802 Madison Ave

state CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & S. —500 Blks.

D 9092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

D 9092

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2859 W. North ave ST.; 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A Blades

(Residence in Baltimore: No. 2859 W. North ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ...Mar 3.... (Month) ....3.... (Day) ....1837.... (Year)

7-AGE,	If LESS than 1 day,
....78.... yrs. ....mos. ....ds.	....hrs. or ....mtn.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... at Home....
(b) General nature of Industry, business, or establishment in which employed (or employer).... 000....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Josiah Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Wingate

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Mrs J. H. Thomas ....

(Address) 2859 W. North ave

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Oct.... (Month) ....6.... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1916, to Oct 6 1917, that I saw h.r alive on Oct 7 1917, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

....

....Arteriosclerosis....

.... (Duration)....6....yrs....mos....ds.

CONTRIBUTORY (Secondary) Senile Debility (Duration)....3....yrs....mos....ds.

(Signed)....H. K. Mactin....M. D.

Oct 8., 1917 (Address) 2737 W North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Mt. St. Michaels md

DATE OF BURIAL, Oct 11., 1917

20-UNDERTAKER H. M. Cook

ADDRESS 502 E North

D 9091 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9091

CERTIFICATE OF DEATH.

REGISTERED NO. C 17

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine F. Myers

(Residence in Baltimore: No. 1305 E. Chase St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 22, 1872 (Month) (Day) (Year)

7-AGE, 45 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jos. Myers

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Fannie ——

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Myers

(Address) 1306 E. Chase

15- OCT 9- 1917 ROBERT B. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism
Struck by Automobile
Accident (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) H. Hunt Cowley M. D.
(Coroner.)

Oct 8, 1917 (Address) 1306 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 2 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?..... Bay & Baroline Sts.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Oct 10 1917
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Oldham St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9095

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1406 Franklin ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S. J. Tighe

(Residence in Baltimore: No. 1406 Franklin St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, Aug. 14, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Rudolph E Tighe

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Alice Price

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Tighe

(Address) 1406 Franklin St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7th 1917, to Oct 9 1917, that I saw h.... alive on Oct 8th 1917, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 5 hrs. ds.

(Signed) Chas. W. Burkert M. D.

Oct. 9th 1917. (Address) 1100 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudendal — DATE OF BURIAL, Oct. 10, 1917.

20-UNDERTAKER M. Fahey & Sons — ADDRESS 606 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D 9096

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Trawinsky

(Residence in Baltimore: No. 720 S. Bond st St.; 32 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. April (Month) ..... (Day) 1885 (Year)

7-AGE. 32 yrs. 6 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Zygadlo

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER not Known

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Trawinski

(Address) 720 S. Bond St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct (Month) 8th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6 am 10-9-17 191 , to 12 m. 10-8-17 191 ,

that I saw h[illegible] alive on 10-8-17 191 ,

and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Pleuritis Carcinomatosa

..... (Duration) .....yrs. 8 mos. .....ds.

CONTRIBUTORY (Secondary)

Debility (Duration) .....yrs. .....mos. .....ds.

(Signed) Dr. Isaac Jacobson M. D.

Oct 8, 191 7 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Rozary

DATE OF BURIAL. Oct. 10, 1917

20-UNDERTAKER. Jacob Trakowski

ADDRESS 428 S. Bond St.

D 9097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 830 S.Eutaw. ST.: 21 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Smith.(C)

(Residence in Baltimore: No. 830 S.Eutaw St. St.: ~~Yrs.~~ ~~mos.~~ 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Single.

6-DATE OF BIRTH, September 19th. 1917. / (Month) (Day) (Year)

7-AGE, ~~Yrs.~~ ~~mos.~~ 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick Smith.(C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Annie Smith.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Smith.(C) mother.

(Address) 830 S.Eutaw St.

15-

OCT 9- 191

ROBERT R. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the Umbilicus.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) [signature] M. D. (Coroner)

Oct. 7. 1917. (Address) 1017 S.Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Oct 9, 1917

20-UNDERTAKER	ADDRESS
Woods Funeral	661 Pitt St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9093

CERTIFICATE OF DEATH.

81 D 9093

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2717 Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ignatius Pults Sr.

(Residence in Baltimore: No. 2717 Mosher St.; 59 yrs., ... mos ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..8.. (Month) ..11.. (Day), 1858 (Year)

7-AGE, ..71.. yrs. ..1.. mos. ..27.. ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..Cooper for 073
(b) General nature of industry, business, or establishment in which employed (or employer) ..B. O. R. R.

9-BIRTHPLACE, (State or Country), Winchester Va.

PARENTS.

10-NAME OF FATHER, John W. Pults

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henrietta Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..Mrs. R. Alverda Pults

(Address) ..2717 Mosher St.

15-

Filed ....., 191.....

Registrar.

OCT 9- 1917 ROBERT B. KRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..October.. (Month) ..8.. (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 4 1917, to Oct 5 191.., that I saw him alive on Oct 7 191.., and that death occurred, on the date stated above, at 3.35 A. m.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

..... (Duration) ..7.. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 8, 1917 (Address) ..2109 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Woodlawn Cemetery	Oct. 8.. 1917.
20-UNDERTAKER Joseph D. Cook	ADDRESS 1003 W. Baltimore St.

Important. See instructions on back

D 9099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9099

CERTIFICATE OF DEATH.

175

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph Weiner

(Residence in Baltimore: No. 1924 Eichner St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, Aug 11, 1906
(Month) (Day) (Year)

7-AGE, 11 yrs. 5 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Louis Weiner

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Rose Hellinger

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE.

(Informant) Rose Hellinger

(Address) 1724 Eichner St.

15-

Filed OCT 9- 1917, 191.... ROBERT B. KRAETER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation. Struck by automobile.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Sharkey Jr. M. D.
(Coroner.)

Oct 9, 1917 (Address) 4 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 2 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Eager St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel

DATE OF BURIAL, Oct 9, 1917

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9100

CERTIFICATE OF DEATH.

8 D 9100

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 N. Wolfe ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Gale

(Residence in Baltimore: No. 1017 N. Wolfe St ST.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col. A. a

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Sing'l

6-DATE OF BIRTH: May (Month) 4 (Day), 1917 (Year)

7-AGE: ..... yrs. 5 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 00
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Benj Roy

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Helen Gilmore

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Edna Roy

(Address) 1017 N. Wolfe St

15-

OCT 9- 1917 ROBERT B. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1917, to Oct 7, 191..., that I saw her alive on Oct. 7, 1917, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) H. C. Kirwan M. D.

Oct 9, 1917 (Address) 1520 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, Oct 9, 191...

20-UNDERTAKER Chas H. Bailey

ADDRESS 1427 Hilton St

D 9101 Eugenie K Foster

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

REGISTERED No. C D 9101

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1823 Hanover St ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugenie Kuhn Foster

(Residence in Baltimore: No. 1823 Hanover St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec (Month) 21 (Day), 1888 (Year)

7-AGE: 28 yrs. 9 mos. 18 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Philip Kuhn

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Jennie Moreland

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victoria Gallagher, Sister

(Address) 1823 Hanover St

15-

Filed OCT 9- 1917, 191 ROBERT B. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 8th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1917, to Oct 8th 1917, that I saw her alive on Oct 8th, 1917, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Personal Knowledge (Duration) yrs. 7 mos. ds. Entry 2 years

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Henry B Coll M. D.

Oct 8th, 1917 (Address) 1703 Eight

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem | DATE OF BURIAL: Oct 10, 1917

20-UNDERTAKER: Mrs. E. Evans & Son | ADDRESS: 1428 N. Charles

28

State CAUSE OF DEATH in plain terms, so that a stranger can understand it. Do not use abbreviations or symbols. Be sure to answer every question. Signature of informant is very important. See instructions on back of certificate.

D 9102

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 9102

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 508 N. Broadway ST.: 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Goldberg

(Residence in Baltimore: No. 508 N. Broadway St.: 21 yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct. (Month) 6 (Day), 1896 (Year)

7-AGE: 21 yrs. mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

PARENTS

9-BIRTHPLACE (State or country): Baltimore Md

10-NAME OF FATHER: Max Goldberg

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Jennie Beiss Wintraub

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Max Goldberg

(Address) 508 N Broadway

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1917, to Oct. 8 1917, that I saw h[illegible] alive on Oct 8 1917, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis Mitral Insufficiency & Stenosis

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY) Embolism & Paralysis

(Duration) yrs. mos. 11 ds.

(Signed) M. S. Hoffman, M. D.

Oct 9th, 1917 (Address) 1731 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Blair Rd

DATE OF BURIAL: Oct 9. 1917

20-UNDERTAKER: S. Levinson & Bro

ADDRESS: 1107 E Balto St

State CAUSE OF DEATH in plain terms, so that it may be properly coded. It is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9103

CERTIFICATE OF DEATH.

79 D 9103

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7346 Lexington ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Raeder

(Residence in Baltimore: No. 2411 Linden Ave

St.; 63 yrs., 10 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 17, 1853 (Month) (Day) (Year)

7-AGE, 63 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Rudolph

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Faegen

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Raeder

(Address) 2411 Linden Ave

15-

Filed....., 191.....

HARRY C. ANDREWS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) F. Edward Smith (Coroner) M. D.

Oct 8, 1917. (Address) 918 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cremation London Park — DATE OF BURIAL, Oct 11, 1917

20-UNDERTAKER Mrs Mrs Jno. W. Teufel — ADDRESS 801 W Fayette

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9101 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9101

CERTIFICATE OF DEATH.

20

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 N Carlton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Dailey

(Residence in Baltimore: No. 1019 N. Carlton St.: 15 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. (Month) 24 (Day), 1877 (Year)

7-AGE, 39 yrs. 10 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) 074

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Nathan Dailey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Snowden

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. D Dailey

(Address) 1019 N. Carlton

15-

Filed....., 191.....

Registrar.

HARRY C. ANDREWS
OCT 9- 1917
REGISTRAR OF VITAL STATISTICS

over

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Oct 8 1917, that I saw h[illegible] alive on Oct. 7 1917, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cellulitis (Purulent) of left thigh & Sepsis (See remarks)

(Duration) yrs. 1 mos. 3 wks ~~ds.~~

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank D Lyon M. D.

Oct 8, 1917. (Address) 1619 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, S. Marks C.A. Co Md | DATE OF BURIAL, Oct 10 1917.

20-UNDERTAKER Sam'l H Chase & Son | ADDRESS 1400 McCulloh

Important. Safeguard

Spec.—8-24-14—M. & T.—2000 Bks.

D 9105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9105

CERTIFICATE OF DEATH.

+41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St.; Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ida Allen

(Residence in Baltimore: No. In Hospital ~~Laurel Md.~~ St.; ....yrs.. ....mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) ~~Married~~

6-DATE OF BIRTH, Nov. (Month) ..... (Day) ....., 1862 (Year)

7-AGE. 54 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic ~~Duties at home~~
(b) General nature of industry, business, or establishment in which employed (or employer)..... Duties at home

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Richard Snowden

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Debby Snowden

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geny. Snowden

(Address) Attleton, Howard Co.

15-

Filed OCT 9- 1917, 191..... HARRY C. ANDREWS Registrar.

Burial I.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27th 191..., to Oct 8th 1917, that I saw h[illegible] alive on October 8th 1917, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Post-operative ulcers and suppression of urine

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of sigmoid

..... (Duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) C. C. C. Childs M. D.

Oct 8th, 191.7. (Address) Md General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Laurel Md

19-PLACE OF BURIAL OR REMOVAL, Freetown Cem. DATE OF BURIAL, Oct 10., 191.7.

20-UNDERTAKER Howard Co Md Easton's Sons ADDRESS Ellicott City

CASE OF DEATH from violence must be reported to Coroner at once. Certificate must be filled out before body is removed. Every question must be answered if possible. Omissions cause delay and are important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9106

CERTIFICATE OF DEATH.

120 D 9106

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1324 West St. ST.: 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Haynes.

(Residence in Baltimore: No. 1324 West St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	Col	Married

6-DATE OF BIRTH, Unknown, 1 .....
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Harness
(b) General nature of industry, business, or establishment in which employed (or employer) Maker 088

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Jones Haynes

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Maher

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Haynes

(Address) 1324 West

15-

Filed....., 191.....
Registrar.

CAUSE OF DEATH to be filled in by Physician only. Important. See instructions on back of certificate. 31

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq.
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq.
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Senile Nephritis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

101... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	Oct 10, 19 7.
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Mt.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E Pratt ST.; V WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cathrein Command

(Residence in Baltimore: No. 1711 E Pratt St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, April (Month) 5 (Day), 1831. (Year)

7-AGE, 66 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer): at home 00

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Brady

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Won't know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Command

(Address) 1711 E. Pratt

15-

Filed....., 191.... HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 7 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 191 7, to Oct 7 191 7, that I saw h[illegible] alive on Oct 7 (7) 191 7, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Sub Acute Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. 3 mos. ds.

(Signed) [illegible] M. D.

Oct 9, 191 7 (Address) 125 S Potomac

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Oct. 10, 1917
20-UNDERTAKER	ADDRESS
Wendell Wippel & Son	32 S Amm

Spec.—8-24-14—M. & T.—2000 Blks.

D 9103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9103

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 Stockton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Cecilia Wade

(Residence in Baltimore: No. 1350 Stockton St.; ....yrs. 9 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ...September...., 1 .... (Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Bailey

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ellen Wade

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Wade

(Address) 2126 Druid Pl

15-

Filed ....., 191.... Registrar.

OCT 10 1917 ROBERT E. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1917, to Oct 7 1917, that I saw h[illegible] alive on Oct 7 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) C. Wallace Frey M. D.

Oct 9, 191.. (Address) 1728 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Oct. 10, 191.7.

20-UNDERTAKER Felix T. Joyce

ADDRESS 1822 E. Madison

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9109 — 170 — D 9109

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Guyon Falls Park. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noah F. Fulton

(Residence in Baltimore: No. Guyon Falls Park. St.; about 30 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug. (Month) 27 (Day) 1840 (Year)

7-AGE, 77 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Superintendent
(b) General nature of industry, business, or establishment in which employed (or employer): of Guyon Falls Park.

9-BIRTHPLACE. (State or Country), London, England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. N. F. Fulton

(Address) Guyon Falls Park

15-

OCT 10 1917 — ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 8th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1917, to Oct 8th 1917, that I saw him alive on Oct 7th 1917, and that death occurred, on the date stated above, at 5.50 a.m.

The CAUSE OF DEATH* was as follows:

Gangrene. Embolism at the junction of the Dorsalis Pedis with its Tarsal branch. (Right foot)

..... (Duration) ....yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ....yrs. 2 mos. 13 ds.

(Signed) E. Dwr. Plummer M. D.

Oct. 8/17 191... (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Trinity Chapel Cemetery Howard Co Md. DATE OF BURIAL. October 10 1917.

20-UNDERTAKER Chas. G. Black ADDRESS 1201 W Mulberry St

D 9110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 79

CITY OF BALTIMORE (No. 628 Sarah Ann ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Stewart

(Residence in Baltimore: No. 628 Sarah Ann St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	Col.	Married

6-DATE OF BIRTH, ... (Month) 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Easter

(Address) 916 Pennsylvania ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic tubercular Pulmonary disease

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) C. P. Donovan M. D.
(Coroner)

Oct 9, 1917. (Address) 312 W Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
W. J. Auburn	Oct 10, 1917
20-UNDERTAKER Samuel Easter	ADDRESS 916 Pennsylvania ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9111

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S Collington ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Wiessner

(Residence in Baltimore: No. 514 S. Collington Ave ST.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 20, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City Md.

PARENTS.

10-NAME OF FATHER, Joseph Wiessner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City Md

12-MAIDEN NAME OF MOTHER Kunigmid Braun

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Wiessner

(Address) 514 S. Collington Ave

15-

OCT 10 1917 ROBERT E. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to Oct 7 1917, that I saw h— alive on Oct 7 1917, and that death occurred, on the date stated above, at 1-a m.

The CAUSE OF DEATH* was as follows:

.....

.....

Enteritis

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY Enteritis
(Secondary)

..... (Duration) ....yrs. ....mos. 3 ds.

(Signed) ..... M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	Oct 11, 191?
20-UNDERTAKER H. Sauder & Son	ADDRESS 1710 Eut St.

D 9112 HEALTH DEPARTMENT—CITY OF BALTIMORE

Russell Pree

CERTIFICATE OF DEATH.

D 9112

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1043 W Saratoga ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Pree

(Residence in Baltimore: No. 123 W Henrietta St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Married

6-DATE OF BIRTH, July (Month) 10 (Day), 1876 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 2 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter 086
(b) General nature of industry, business, or establishment in which employed (or employer): Colored Club

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Pree

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Lydia Diggs

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Pree

(Address) 123 W. Henrietta St.

15-

Filed....., 191.....

Registrar.

OCT 10 1917 ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Sclerosis of Coronary

Artery (Duration) ....yrs. 6 mos. ....ds.

(Signed) James M. Hundley M. D.
(Coroner.)

Oct 8, 1917. (Address) 720 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Oct 10, 1917
20-UNDERTAKER John H. Toadvine	ADDRESS 1426 Pine St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9113

CERTIFICATE OF DEATH.

40 D 9113

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 E. Fairmount ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea E. Spindler

(Residence in Baltimore: No. 2213 E Fairmount Av St.; 35 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 1st (Day) 1850 (Year)

7-AGE, 67 yrs. 3 mos. 9 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER. (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Zimmerman

(Address) 2213 E. Fairmount

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 9th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Oct 9 1917, that I saw her alive on Oct 7 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Progressive Cancerous Disease of Stomach (Clinical diagnosis)

(Duration) ..... yrs. poor mos. ..... da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. 1 mos. ..... da.

(Signed) W. J. Ickner M. D.

Oct 10, 1917. (Address) 701 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Oct 12 1917

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

D 9111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 9117

1-PLACE OF DEATH
CITY OF BALTIMORE; (No. 23 N. Eden St.; 5 WARD)
REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Velenchick

(Residence in Baltimore: No. 23 N Eden St. St.; 4 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown ....., 18..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School 068
(b) General nature of industry, business, or establishment in which employed (or employer)..... Teacher

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Lewis

(Address)..... 1411 E Balto St

15-

Filed....., 191.....

Registrar.

OCT 10 1917 ROBERT N. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Oct 9 1917, that I saw h[illegible] alive on Oct 9 1917, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Annular Carcinoma of Cardiac end of Stomach, no operation as ..... (Duration) ..... yrs. 10 mos. ..... ds.
atopy

CONTRIBUTORY (Secondary) Cardiac Asthenia ..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Herman Lewis M. D.

Oct. 9, 1917. (Address) 1931 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
North Pan Mt Carmel	10/11, 191.7.
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

D 9115

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

142 ✓

D 9115

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2020 Druid Hill Ave St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily A. Slaughter

(Residence in Baltimore: No. above St.: 106 yrs. 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: March 1, 1811 (Month) (Day) (Year)

7-AGE: 106 yrs. 7 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Unknown Anderson

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Emily

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Slaughter

(Address) 2020 Druid Hill Ave

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 7th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1917, to Oct 7th 1917, that I saw h[er] alive on Oct 5th, 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Epidermoid Cancer, Groin

& Anemia

over

(Duration) ..... yrs. 1 mos. 6 ds.

Contributory (SECONDARY) Gangrene of left foot

(Duration) ..... yrs. 5 mos. ds.

(Signed) L. Schaaf M. D.

Oct 7th, 1917 (Address) 211 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Oct 10, 1917

20-UNDERTAKER: Samuel Handley

ADDRESS: 5 S. Bridge

state CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

D 9116

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9116

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 511 Franklin Terrace ST.; 9 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J Farley

(Residence in Baltimore: No. 511 Franklin Terrace St.: 57 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Widowed

6-DATE OF BIRTH Feb (Month) 5 (Day), 1860 (Year)

7-AGE 57 yrs. 8 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

037

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Wm McClelland

11-BIRTHPLACE OF FATHER (State or country) England

12-MAIDEN NAME OF MOTHER Mary Jane Russell

13-BIRTHPLACE OF MOTHER (State or country) Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Nettie Farley

(Address) 511 Franklin St

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct 8. (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2. 1916, to Oct 8 1917, that I saw h[illegible] alive on Oct 8 1917, and that death occurred, on the date stated above, at 2.15 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) XXX yrs. 11 mos. 6 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), E. G. Dunkiss M. D.

Oct 9. 1917 (Address) 634 Gorsuch Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount Cem | DATE OF BURIAL 10/11 1917

20-UNDERTAKER George A Farley | ADDRESS Fulton - Fayette

State CAUSE OF DEATH in plain terms. It is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9117

CERTIFICATE OF DEATH.

28 ✓ D 9117

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 N. Duncan ST.; 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Weber

(Residence in Baltimore: No. 1736 N. Duncan St.

Ge yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Aug 15, (Month) (Day) 1881 (Year)

7-AGE: 36 yrs. 1 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber 004
(b) General nature of industry, business, or establishment in which employed (or employer): In business

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Christian Weber

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margrate Eberman

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nellie P. Weber

(Address) 1736 Duncan St

15-

OCT 10 1917 ROBERT R. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 9, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1917, to October 9, 1917, that I saw him alive on October 8, 1917, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Edward L. Stanley, M. D.

Oct. 9, 1917. (Address) 1223 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loch Lawn Cemetery

DATE OF BURIAL: Oct. 12, 1917.

20-UNDERTAKER: Robt. J. Turner

ADDRESS: 1442 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9118

D 9118

CERTIFICATE OF DEATH.

28v

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Colvin ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Cooper

(Residence in Baltimore: No. 1728 Orleans St.; 35 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	a. g	Single

6-DATE OF BIRTH, May (Month), (Day), 1883 (Year)

7-AGE, 35 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boot 08
(b) General nature of industry, business, or establishment in which employed (or employer): Black

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Cooper

(Address) 1730 Orleans St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 8, (Month), (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1917, to Oct. 8 1917, that I saw h[illegible] alive on Oct. 8, 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) ? yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

Oct. 9, 191.. (Address) 1520 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Asbury Cem	Oct. 11th, 191.7.

20-UNDERTAKER Harry A. Vodary ADDRESS 1715 Orleans St

C. E. DUNIGAN
NOTARY PUBLIC
BALTIMORE, MD.

Oct. 16, 1917.

To Whom it may Concern;

I hereby certify that Clarence Cooper's certificate signed by me to the effect of this having Phthisis 6 yrs. was a mistake, and should have been 6 mos., he has had the trouble.

Jno. C. Robinson, M.D.

State of Maryland.
City of Baltimore

I hereby certify that on this the sixteenth day of October, 1917, before me the subscriber a Notary Public of the State of Maryland, in and for the City of Baltimore, personally appeared Jno. C. Robinson, M.D. and made oath in due form of law that the statement set forth above is true.

Caroline E. Dunigan
Notary Public

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9119 ✓ D 9119

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1345 Jackson St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie E. Kraft

(Residence in Baltimore: No. 1345 Jackson St.; ....yrs., mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sup

6-DATE OF BIRTH, Sept 10, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Kraft

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Nellie Howe

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Howe.

(Address) 1345 Jackson St.

15-

Filed ....., 191.... Registrar.

OCT 10 1917 ROBERT R. KRAETER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Oct 10 1917, that I saw h alive on Oct 9 1917, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Contributory Exhaustion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. 10 ds.

(Signed) R. L. Campbell M. D.

Oct 10, 1917. (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, Oct 12, 191..

20-UNDERTAKER Wm J. Adam Son

ADDRESS 1417 W. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9120 ✓ 37 D 9120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. General Hospital REGISTERED No. C.....

CITY OF BALTIMORE: (No. Lanvale & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Banks.

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Negro	Infant

6-DATE OF BIRTH, October 6, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 2 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Robinson

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Florence Banks

13-BIRTHPLACE OF MOTHER (State or Country), Washington, D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

OCT 19 1917 UNIVERSITY OF MARYLAND. Commissioner Health.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 6 1917, to October 8 1917, that I saw her alive on October 8 1917, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Luetic Hepatitis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. 19 ....ds.

(Signed) F. P. Powers, M. D.

10-10-1917 (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. 2 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
	OCT 19 1917, 191...
20-UNDERTAKER	ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 912[illegible] **CERTIFICATE OF DEATH.** 151 D. 9121

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Linden Ave. & Madison ST.; 11 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Gillis

(Residence in Baltimore: No. Clifant St.; ....yrs.,....mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Negro	Infant

6-DATE OF BIRTH, September 19, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Doc

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Gillis

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elvira Gillis

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Oct. 9 1917, that I saw h[illegible] alive on Oct. 9 1917, and that death occurred, on the date stated above, at 4.56 p.m.

The CAUSE OF DEATH* was as follows:

Acute inanition

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) J. H. Roberts M.D. M. D.

10-10....., 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos. 19 ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	OCT 10 1917

20-UNDERTAKER	ADDRESS
Commissioner Health.	

UNIVERSITY OF MARYLAND

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9122

CERTIFICATE OF DEATH.

47 ✓ D 9122

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 718 N. Caroline ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Roden

(Residence in Baltimore: No. 718 N. Caroline St.; 22 yrs., 8 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, January 11th, 1895 (Month) (Day) (Year)

7-AGE, 22 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work 037
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Weston K. Brown

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Annie B. Robbins

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie B. Brown

(Address) 718 N. Caroline St

15-

Filed....., 191.....

Registrar.

OCT 10 1917 ROBERT R. KRAUTER Deputy Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1917, to Oct 7th 1917, that I saw her alive on Oct 5th 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Cardiac Dropsy (Duration) ...yrs. 4 mos. ...ds.

CONTRIBUTORY (Secondary) Acute Inflammatory Rheumatism (Duration) ...yrs. 3 mos. ...ds.

(Signed) Thomas E. Mackenzie M. D.

Oct 8th, 191.7. (Address) 1339 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Oct 10, 1917

20-UNDERTAKER A. E. Gross — ADDRESS 1405 W. Lafayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9123 D 9123

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert D. Little

(Residence in Baltimore: No. Mercy Hospital St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, DIVORCED (write the word.)
Male	White	Married

6-DATE OF BIRTH, May 29, 1877
(Month) (Day) (Year)

7-AGE, 40 yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cement 083
(b) General nature of industry, business, or establishment in which employed (or employer): Worker

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, David Little

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Scaff

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ward Mercy Hosp

(Address) Calvert St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 25 1917, to Oct. 10 1917, that I saw him alive on Oct 10 1917, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

about (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Edward L. Smith M. D.

Oct 10, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 15 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Arlington Md

Former or usual residence 3 Academy Ave. Arlington Md.

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Oct 10, 1917

20-UNDERTAKER W. M. Buckler ADDRESS Govans North Pa.

D 9121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9121

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bell & Poca ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen L. Lowry

(Residence in Baltimore: No. 1917 O'Donnell St / St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 28 (Day) 1895 (Year)

7-AGE, 22 yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machine Lom
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Nathan Lowry

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary B Lukes

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Scheeler

(Address) 19 N. Kenwood Ave

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. Edward Smith M. D.
(Coroner)

Oct 9, 191. (Address) 910 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Oct. 11., 1917.
20-UNDERTAKER	ADDRESS
N. S. Frank	1921 N. Patterson

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

9125

CERTIFICATE OF DEATH.

17 D 9125

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 E. German St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Robinson

(Residence in Baltimore: No. 818 Bolton Alley St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) (Year)

7-AGE, 28 yrs. 29 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Elevator Man
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Edward H Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Lee Hall

13-BIRTHPLACE OF MOTHER (State or Country), Leander Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florance Chandler

(Address) 1410 Hand st.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull and Crush of Chest by Elevator in Hotel Belvidere, accidental

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) W H Fiddes (Coroner.) ..... M. D.

Oct 9, 191 7 (Address) 16 E Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct. 12, 1917
20-UNDERTAKER Willet Brown.	ADDRESS 114 N. Howard St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9126

CERTIFICATE OF DEATH.

28

D 9126

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 W. Lexington ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Eva Garrett

(Residence in Baltimore: No. 1036 W Lexington St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August, 1 (Month) (Day), ... (Year)

7-AGE, 28 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Washington D C.

PARENTS.

10-NAME OF FATHER, John Lloyd

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Clara Stevens

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Garrett

(Address) 1036 W. Lexington st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Oct 8 1917, that I saw her alive on Oct 7 1917, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) ..... yrs. 1 mo. 21 ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ..... yrs. mos. 2 ds.

(Signed) O. H. Hinkel M. D.

Oct 9, 1917 (Address) 1125 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 11, 191.7

20-UNDERTAKER Hillert Brown

ADDRESS 1144 N. Schroder st.

OCT 10 1917 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9127

CERTIFICATE OF DEATH.

D 9127

1-PLACE OF DEATH

REGISTERED No. C 180

CITY OF BALTIMORE: (No. Esplanade apts ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob L. Frank

(Residence in Baltimore: No. Esplanade apt St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 1, 1853
(Month) (Day) (Year)

7-AGE, 63 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Merch't

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Leon Frank

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Regina Bloodman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M H Frank

(Address) Esplanade apts

15-

Filed....., 191.....
Registrar.

HARRY U. [illegible]
OCT 10 1917
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1915, to Oct 9 1917, that I saw h[illegible] alive on Oct 9 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. mos. ds.

(Signed) Jos. L. Hirsh M. D.

Oct 10 1917 (Address) 2360 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew

DATE OF BURIAL, Oct 11, 1917.

20-UNDERTAKER Hart & Sondheim

ADDRESS 10 N Howard St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Durham St.; 2 Ward) REGISTERED NO. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willfus Young

(Residence in Baltimore: No. 114 S. Durham St St.: 6 yrs.. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, April 11, 1911
(Month) (Day) (Year)

7-AGE, 16 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 040
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Pick + Shovel

9-BIRTHPLACE, (State or Country), Prince George Co Md

PARENTS.

10-NAME OF FATHER, William Young

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Laura Boyd

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Young

(Address) 114 S. Durham

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 5 1917, that I saw him alive on Oct 5 1917, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ...yrs. 4 mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs....mos. 30 ds.

(Signed) S. T. Rodden M. D.

....., 191... (Address) 1304 E. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 11, 1917

20-UNDERTAKER Theodore Wirth ADDRESS 1126 Hollins St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9129 D 9129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfield Snyder

(Residence in Baltimore: No. 17 days in Hospital St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, November (Month) 9 (Day), 1916 (Year)

7-AGE, ...yrs. 11 mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Wm Snyder

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Melvina Phillips

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

OCT 10 1917 HARRY C. ARCHER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917 to Oct 9 1917, that I saw h[im] alive on October 9 1917, and that death occurred, on the date stated above, at 3.10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage (post-operative)

..... (Duration) .....yrs. .....mos. 15 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Henry B. Conrad M. D.

Oct. 9, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 17 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence St George W. Va

19-PLACE OF BURIAL OR REMOVAL, Salisbury W. Va — DATE OF BURIAL, Oct 10, 1917

20-UNDERTAKER H W Laird & Son — ADDRESS 647 N Pine

Spec.—8-24-14—M. & T.—2000 Bks.

D 9130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Muhl

(Residence in Baltimore: No. 224 Maryland Ave. St.; ... yrs., ... mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 27, 1917
(Month) (Day) (Year)

7-AGE, 6 months
...yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas A Muhl

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Emma Mingert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas A. Muhl

(Address 224 Maryland ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8, 11 AM 1917, to Oct 8 1917, that I saw him alive on Oct 8 PM 1917, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Shock ..... (a)
..... (b)
Cerebral hemorrhage ..... (c)
..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction
2 days (?) (Duration) ... yrs. ... mos. ... ds.

(Signed) H. T. Kemp Forrest M. D.
Oct 8, 1917. (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. (date of arrival in State) ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 224 Maryland ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 11, 1917

20-UNDERTAKER Josiah Sypher & Son — ADDRESS 16 & W North ave

D 9131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 9131

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4400 Pimlico Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. Norman Steigelman

(Residence in Baltimore: No. 4400 Pimlico Road St.: yrs. 43 mos. 7 ds. 22)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... Sept. (Month) 17, (Day) 1874 (Year)

7-AGE, 43 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Printer
(b) General nature of industry, business, or establishment in which employed (or employer) 063

219

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, C. Steigelman

11-BIRTHPLACE OF FATHER (State or Country), German

12-MAIDEN NAME OF MOTHER, Sadie Norman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Steigelman

(Address) 4400 Pimlico Road

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Coroner. M. D.

Oct 10 191 7 (Address) 760 2 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Oct 11, 1917
20-UNDERTAKER R. Sanderson	ADDRESS 1710 Reed St

HARRY G. ARCHER
OCT 10 1917
Burial Permit Clerk

important. See instructions on back of certificate.

D 9132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 19 D 9132

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2736 W Lafayette Ave 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Le Roy W Stewart

(Residence in Baltimore: No. 2736 W Lafayette Ave St.; Yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1914 (Year)

7-AGE, 3 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Ira Stewart

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Emma L. France

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ira Stewart

(Address) 2736 W Lafayette Ave

15-

Filed ....., 191.....

Registrar.

CAUSE OF DEATH. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 9 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (1) (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (Duration) yrs. mos. ds.

(Signed) O J Williams M. D.

(Coroner.)

Oct 9, 1914. (Address) 819 K Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 11, 1914

20-UNDERTAKER William Cook

ADDRESS 507 E North

Spec.—8-24-14—M. & T.—2000 Bks.

D 9133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9133

CERTIFICATE OF DEATH.

28

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Hickory Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Ambrose

(Residence in Baltimore: No. 3704 Hickory Ave St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug 12, 1889
(Month) (Day) (Year)

7-AGE, 28 yrs. 1 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Grocer 034
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Store Keeper

9-BIRTHPLACE, (State or Country), Cockeysville Md

PARENTS.

10-NAME OF FATHER, Isaac R Ambrose

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Mary E Yasuck

13-BIRTHPLACE OF MOTHER (State or Country), Cockeysville Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Ambrose

(Address) 3704 Hickory Ave

15-

OCT 10 1917 HARRY M. ANDREWS Registrar Baltimore City

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Oct 10 1917, that I saw him alive on Oct 9 1917, and that death occurred, on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 4 yrs. 9 mos. 1 ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

..... (Duration) 1 yrs. 2 mos. 2 ds.

(Signed) D. F. Benson M. D.

Oct 10, 1917. (Address) Lutherville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Relay Md — DATE OF BURIAL, Oct 14, 1917.

20-UNDERTAKER W B Cook — ADDRESS 501 E North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9134

CERTIFICATE OF DEATH.

64

D 9134

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1748 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME John T. Elliott

(Residence in Baltimore: No. 1748 Orleans St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 18, 1852
(Month) (Day) (Year)

7-AGE, 64 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, Robert Elliott

11-BIRTHPLACE OF FATHER (State or Country) Balto City

12-MAIDEN NAME OF MOTHER Elizabeth Mobley

13-BIRTHPLACE OF MOTHER (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. R. Elliott

(Address) 608 N. Eddington Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Oct 8 1917, that I saw h[illegible] alive on Oct 8 1917, and that death occurred, on the date stated above, at 10 50 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Cerebro Pulmonary

(Duration) yrs. mos. ds.

(Signed) W. [illegible], M. D.

Oct 9, 1917 (Address) 200 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Oct 11, 1917

20-UNDERTAKER Willard C. Fuller

ADDRESS 221 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

D 9135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9135

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 N Calhoun ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Allen

(Residence in Baltimore: No. 1513 N Calhoun St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH, Date Unknown, 1860
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Texas U S

PARENTS.

10-NAME OF FATHER, Date Unknown

11-BIRTHPLACE OF FATHER (State or Country), Texas U S

12-MAIDEN NAME OF MOTHER Lena Jones

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Allen

(Address) 1513 N Calhoun St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1917, to Oct 7 1917, that I saw him alive on Oct 7 1917, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) ... yrs. ... mos. 8 ds.

(Signed) D. William Frey M. D.

Oct 8, 1917 (Address) 1728 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn — DATE OF BURIAL, Oct 11, 1917.

20-UNDERTAKER John E Brown — ADDRESS 1351 Lanvale

Important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9133

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Jacobs

(Residence in Baltimore: No. 2216 McCulloh St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	widow

6-DATE OF BIRTH, May (Month) 16 (Day), 1838 (Year)

7-AGE, 79 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Lazarus Rothschild

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Berliner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav Jacobs

(Address) 1201 N. Monta ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 4 1917, that I saw h— alive on Oct. 4 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jos L. Pierce M. D.

Oct. 10, 191... (Address) 1210 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Mt Olivet — DATE OF BURIAL, Oct. 11., 1917.

20-UNDERTAKER J Ahrens & Co — ADDRESS 1611 Mad ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9137

CERTIFICATE OF DEATH.

D 9137

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 E Fairmount Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Pomarantz

(Residence in Baltimore: No. 2103 E Fairmount Ave St.; ... yrs., 11 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November ..., 1915
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Abe Pomarantz

11-BIRTHPLACE OF FATHER (State or Country), Massachusetts

12-MAIDEN NAME OF MOTHER Yetta Kanier

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Pomarantz

(Address) 2103 E Fairmount Ave

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Oct 10 1917, that I saw her alive on Oct 10 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

... Influenza Caused by Pneumonia
... Contributory to the Latter
... Duration ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ... Influenza
... (Duration) ... yrs. ... mos. 2 0 ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence 2103 E Fairmount Ave

19-PLACE OF BURIAL OR REMOVAL, Arbor Hill Cem

DATE OF BURIAL, Oct 12 1917

20-UNDERTAKER S. Levinson & Bro

ADDRESS E Balto St

D 9133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9133

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 432 E. Cross St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily V. Lanahan.

(Residence in Baltimore: No. 432 E. Cross St. St.: 41 yrs. 2 mos. 8 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White.	Married

6-DATE OF BIRTH, August 1st. 1876., 1..... (Month) (Day) (Year)

7-AGE, 41 yrs. 2 mos. 8 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert Busby.

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Sousan Coughlan.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas F. Lanahan. (husband.)
(Address) 432 E. Cross St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.

(Signed) Otto M. Eisenhardt M. D. (Coroner.)

Oct., 10., 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem.	Oct 11, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9130

CERTIFICATE OF DEATH.

80

D 9130

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 Walbrook ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. Sweedale

(Residence in Baltimore: No. 2141 Walbrook ave, St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 16 (Day), 1839 (Year)

7-AGE, 78 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm B. Ward

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lillie Forrester

(Address) 2141 Walbrook ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1916, to Oct 9 1917, that I saw her alive on Oct 5 1917, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,
Angina Pectoris,
Status (Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Cause Chronic Gastritis
(Duration) ... yrs. 10 mos. 15 ds.

(Signed) H. C. Welsh M. D.

Oct 10, 1917 (Address) 2737 Woodbrook ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Oct 12, 1917

20-UNDERTAKER F. A. Sevause — ADDRESS 703 Howard st

OCT 10 1917 HARRY D. ANDREWS DEPUTY REGISTRAR

Spec.—5-19-13—M. & T.—500 Bks.

D 9140 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9140

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 627 S. Bond ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Feliksina Baranowska

(Residence in Baltimore: No. 627 S. Bond St.; — yrs. 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 1st, 1917
(Month) (Day) (Year)

7-AGE, ..yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Alexander Baranowska

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland

12-MAIDEN NAME OF MOTHER Fronie Batzowska

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fronie Baranowska

(Address) 627 S. Bond St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4 1917, to Oct. 9 1917, that I saw her alive on Oct. 7 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

..... (Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) /

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) John A. Kehlberger M. D.

Oct. 10, 1917. (Address) 1709 Aliceanna St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct 11, 191.7

20-UNDERTAKER M. A. Sadowski

ADDRESS 705 S. Ann

Important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

D 9141

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D 9141

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7836 N Lanvale St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Hullett

(Residence in Baltimore: No. 7836 N Lanvale St.; yrs. 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 20" (Month) (Day), 1916 (Year)

7-AGE, ...yrs. 11 mos. 19 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edgar F Hullett

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Sarah E Hullett

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar F. Hullett.

(Address) 7836 N Lanvale St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1917, to Oct 9 191 , that I saw her alive on Oct 8 191 , and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) ....yrs. ....mos. 7 ds.

(Signed) F. H. Evans M. D.

Oct 11, 191 (Address) 907 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem | DATE OF BURIAL, Oct 11" 191

20-UNDERTAKER Joseph B Cook | ADDRESS 1003 N. Bolton

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9142

CERTIFICATE OF DEATH.

4J ✓ D 9142

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Ashland ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Lo. Givvines

(Residence in Baltimore: No. 1620 Ashland Ave St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Nov. 15, 1843
(Month) (Day) (Year)

7-AGE, 73 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Varnisher
(b) General nature of industry, business, or establishment in which employed (or employer). 051

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Wm Givvines

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah A. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. H. Givvines

(Address) 1620 Ashland ave.

15-

Filed....., 191.....

ROBERT R. REAUTER
Registrar.

OCT 11 1917
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9, 1917.
(Month) (Day) (Year)

17—I HEREBY CERTIFY, That I attended deceased from Feb 12 1917, to Oct 9 1917, that I saw h[illegible] alive on Sept 9 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

(Duration) 5 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. B. Fuller M. D.

Oct 10, 1917. (Address) 830 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 13, 1917.

20-UNDERTAKER Zirkler Zirkler — ADDRESS 1734 E. Eager

Spec.—8-24-14—M. & T.—2000 Bks.

D 9143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9143

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Smith

(Residence in Baltimore: No. 1329 Argyle Ave St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1860
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chambermaid
(b) General nature of industry, business, or establishment in which employed (or employer) M. Boat

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Harris

(Address) 1329 Argyle Ave

15-

OCT 11 1917 ROBERT B. KRAUTER

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct - 9 -, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6. 1917, to Oct 7 1917.
that I saw h[illegible] alive on Oct 7 1917.
and that death occurred, on the date stated above, at 1145 a m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) ..... M. D.

Oct 10, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, 10-11-, 191.7

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W. Lee St

D 9141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 9147

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md Gen. Hosp. St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence J. Garrety

(Residence in Baltimore: No. 122 S. Wolf St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 6 (Day), 1894 (Year)

7-AGE, 26 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm
(b) General nature of industry, business, or establishment in which employed (or employer)..... Worker

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Patrick Garrety

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary McCloskey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... [illegible]

(Address) 122 S Wolf

15-

OCT 11 1917 ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

CAUSE OF DEATH. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

a Accidental Burns.

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Burns of Body

(Duration) yrs. mos. ds.

(Signed) C. F. Wellershaus M. D.

(Coroner)

Oct. 11, 1917 (Address) 819 N Eden

over

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Oct. 13, 1917
20-UNDERTAKER	ADDRESS
H M Shriver	108 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

D 9145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Vincent's Inf. Asylum, REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1401 Division St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Horning,

(Residence in Baltimore: No. 1401 Division St.: ....yrs.. mos. 1½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female,	Wh,	X

6-DATE OF BIRTH, Oct 7, (Month) (Day) 1911 (Year)

7-AGE, ...yrs. mos. 1½ ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), St. Vincent's -

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Horning -

(Address) St. Vincents Inf. Asy.

15-

Filed....., 191...

C. L. T. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, (Month) (Day) 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7, 1917, to Oct 9 1917, that I saw her alive on Oct 9 1917, and that death occurred, on the date stated above, at 4:20 A.m.

The CAUSE OF DEATH* was as follows:

Chief was Cerebral Hemorrhage of 7 mo Convulsions - not given Diagnosed & Treated Lake ms. Nourishment

(Duration)....yrs....mos. 1½ ds.

CONTRIBUTORY (Secondary) none

(Duration)....yrs....mos....ds.

(Signed) Edward M.C. Baker M. D.

....., 191... (Address) 111 W. Hoffman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Oct. 11, 1917.

20-UNDERTAKER H. Fahey & Sons — ADDRESS 221 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9146 92 ✓ D 9146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 314 Myrtle Ave ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fizzie Bailey

(Residence in Baltimore: No. 314 Myrtle Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 6 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laundress

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... William Johnson

(Address)..... 314 Myrtle St

15-

Filed....., 191.....

OCT 11 1917 ROBERT R. KRAUSER Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 8 1917, that I saw h[er] alive on Oct 8 1917 and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

..... (Duration) ....yrs. ....mos. 8 ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. P. Bostwick M. D.

Oct 8, 1917 (Address) 1124 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs. ....mos. ....ds. In the State....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Dead Man's Curve

19-PLACE OF BURIAL OR REMOVAL. West Marlborough — DATE OF BURIAL. Oct 11, 1917

20-UNDERTAKER Charles B. Jones — ADDRESS 235 Pine St

D 9147.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

42 D 9147

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Kris + Cancer Hospital St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida Rosetta Rupp

(Residence in Baltimore: No. 2510 Greenmount Ave St.; 52 yrs. 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Oct. (Month) 9 (Day), 1917 (Year)

7 AGE: 52 yrs. 7 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frederick Smith

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Hise

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Marcus Muth

(Address) 4106 Greenland Ave

15.

Filed ..... 191 .....

ROBERT R. KRAUTER

Burial Permit

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 9 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1914. to Oct. 9 1917. that I saw h[illegible] alive on Oct. 6 1917. and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 2 yrs. 8 mos. ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Innis Edwards M. D.

Oct 9, 1917. (Address) 710 W Mt Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. 1 mos. 12 ds. In the State Md yrs. 52 mos. 7 ds.

Where was disease contracted, if not at place of death? Not Known

Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 11 1917

20 UNDERTAKER: H. E. Stoltzenberg — ADDRESS: Pennsylvania

State CAUSE OF DEATH in plain terms, so that it may be [illegible] is very important. See instructions on back of certificate.

D 9143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9143

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 Old York Rd. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda J Eckhart,

(Residence in Baltimore: No. 124 Old York Rd. St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, May 8, 1846
(Month) (Day) (Year)

7-AGE, 71 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dance
(b) General nature of industry, business, or establishment in which employed (or employer)..... X 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Wisley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Amanda Crissell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Eckhart,

(Address) 124 Old York Rd

15- OCT 11 1917

Filed....., 191.... L. S. P.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jos. Jones Smith M. D.
(Coroner.)

Oct 10, 1917. (Address) 4 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Christ Church Burial Ground Baltimore Md. DATE OF BURIAL, Oct 12, 1917

20-UNDERTAKER Henry Hoerle Sons ADDRESS 130 E Eager St

CAUSE OF DEATH must be stated in every case. Information required is important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9149

CERTIFICATE OF DEATH

40

D 9149

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2946 Harlem Avenue, ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa H. Arand,

(Residence in Baltimore: No. 2946 Harlem Avenue, St.: 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female,

4-COLOR OR RACE: White,

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed,

6-DATE OF BIRTH: January (Month) 12th (Day), 1848. (Year)

7-AGE: 69 yrs. 8 mos. 27 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work: None,

(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE (State or country): Germany,

PARENTS

10-NAME OF FATHER: Robert Handloser,

11-BIRTHPLACE OF FATHER (State or country): Germany,

12-MAIDEN NAME OF MOTHER: Barbara Miller,

13-BIRTHPLACE OF MOTHER (State or country): Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Shea, daughter,

(Address) 2946 Harlem Avenue.

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 9th (Day), 1917. (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 31st, 1917, to October 9th 1917, that I saw her alive on October 8th 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma, (Cancer)

(probably scirrhous)

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Anaemia and toxaemia,

(Duration) 1 yrs. 3 mos. ds.

(Signed) J. Frederick Mundel, M. D.

Oct. 9th, 1917. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct 12th, 1917
20-UNDERTAKER	ADDRESS
John J. Cowan & Sons	20 Hollins St.

OCT 11 1917 HARRY D. ANDREWS

state CAUSE OF DEATH in plain terms, so that ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9150

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

80 D 9150

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 W Townsend St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss M. Bowie Durkin

(Residence in Baltimore: No. 107 W. Townsend St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb 5", 1848
(Month) (Day) (Year)

7-AGE, 69 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Dr Alexander J Durkin

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Caroline T. Keener

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C Bowie

(Address) The Severn apts

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10", 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25" 1917, to Oct 10" 1917, that I saw h.. alive on Oct 10" 1917, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Carcinoma of Peritoneum

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 12, 1917. (Address) 1007 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	Oct 12", 1917.
20-UNDERTAKER	**ADDRESS**
Henry W. Jenkins & Sons	1119 Eutaw St.

Important. See instructions on back.

Spec.—8-24-14—M. & T.—2000

D 915[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓

D 915[illegible]

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Maryland Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delilah W. Courtney.

(Residence in Baltimore: No. 1704 Maryland Ave St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, About 1850 (Month), 1 (Day), ... (Year)

7-AGE, About 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer): Nothing

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Purnell.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Angeline Wood.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louise E. Scarff

(Address) 1704 Maryland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 10th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 18th 1917, to Oct. 9th 1917, that I saw h[illegible] alive on Oct. 9th 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Apoplexy Aug. 18/17 - with partial recovery Bronchia - pneumonia Oct. 8th 1917.

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

10/10..., 191.7. (Address) 2100 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery, Balto. Co. Md. DATE OF BURIAL, 10/12..., 191.7.

20-UNDERTAKER W. W. Cooke ADDRESS North Ave.

GH
Dr Hoffman. 2100 W North ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9152

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9V D 9152

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Moreland Ave ST.; 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winifred C. Carney

(Residence in Baltimore: No. 1506 Moreland Ave St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1857 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Owen P. Carney

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Carlos

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Owen B. Carney

(Address) 1506 Moreland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 191 7, to Oct 4 191 7, that I saw her alive on Oct 4 191 7, and that death occurred, on the date stated above, at 10.50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 5, 1917, (Address) 108 N Carlton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Oct. 7, 1917

20-UNDERTAKER	ADDRESS
Henry B. Browning Son	514 N. Schroeder St

D 9153 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9153

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Broadway & Eastern Ave ST.: 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Jenko (Jenko)

(Residence in Baltimore: No. 844 S Bond St St.; yrs., 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug 8 (Month) (Day), 1 (Year)

7-AGE, 5 1 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Andw Jansan

11-BIRTHPLACE OF FATHER (State or Country) Austria

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jenko

(Address) 844 S Bond St

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Crushing of Chest
by falling from Auto Car
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clarence Wyatt Davis M. D.
(Coroner.)

Oct 9 1917, (Address) 610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct [illegible] 1917

20-UNDERTAKER Frank Enoch & Son — ADDRESS 1900 E Baltimore

Check carefully for omissions and errors. Every item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9154

CERTIFICATE OF DEATH.

REGISTERED NO. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 W Fairmount Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Lee Buppert.

(Residence in Baltimore: No. 2111 W Fairmount Ave St.; Life Time yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, September 9th, 1917. (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm L Buppert

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Marie M Mack

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L Buppert

(Address) 2111 W Fairmount Ave

15-

Filed....., 191.... MARY C. ANTREW Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 10th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Oct 10th 1917, that I saw h alive on Oct 10th 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

(a) Marasmus

(b) Bronchopneumonia Broncho Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Wm L Buppert M. D.

Oct 11, 1917. (Address) 1925 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Rosly Md — DATE OF BURIAL, Oct 11th 1917

20-UNDERTAKER Geo A Garbing — ADDRESS Bucks Rapids

Spec.—8-24-14—M. & T.—2000 Bks.

D 9155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 104 D 9155

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: ?? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Smith

(Residence in Baltimore: No. 6 days - in Hospital St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 9, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lillie Hamel

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Grafton

(Address) John Hopkins Hospital

15-

OCT 11 1917

Filed Oct. 11, 1917

Registrar,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5 1917, to Oct. 11 1917, that I saw him alive on Oct. 11 1917, and that death occurred, on the date stated above, at 5.10 a m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion

Paresis

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY, (Secondary) Bronchopneumonia

..... (Duration) ....yrs. ....mos. 6 ds.

(Signed) Margaret Tyler M. D.

Oct. 11, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State 2 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 2

Former or usual residence Towson, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cleveland Md	Oct. 12., 1917.
20-UNDERTAKER Albert E. Fuller	ADDRESS 231 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9156

CERTIFICATE OF DEATH.

97

D 9156

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Merlini

(Residence in Baltimore: No. 517 Bloom St. St.; —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH. Dec 24, 1893 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
23 yrs. 9 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): Day 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Major Martin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary F. Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lucy Thomas

(Address) 124 Aisquith Lane

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1917, to Oct 10 1917, that I saw him alive on Oct 10 1917, and that death occurred, on the date stated above, at 1.55 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Edward J. Smith M. D.

Oct. 10, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 1 yr. ....mos. ....ds.

Where was disease contracted, if not at place of death? 517 Bloom St.

Former or usual residence 517 Bloom St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn cem	Oct 12, 1917

20-UNDERTAKER Jno H Holland ADDRESS 1631 Dtt ave

Spec.—5-19-13—M. & T.—500 Bks.

D 9157 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 9157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 615 Bradley ST.; 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Lenn

(Residence in Baltimore: No. 615 Bradley St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Public Off

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen G. Lenn

(Address) 615 Bradley Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Oct. 9 1917, that I saw h[illegible] alive on Oct 9 1917, and that death occurred, on the date stated above, at 9 20 m.

The CAUSE OF DEATH* was as follows:

a .....

b Pulmonary Tuberculosis

c .....

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 10, 1917 (Address) 206 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Lebanon — DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER George H. Holland — ADDRESS 1631 N. Broadway

Important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9153 D 9153

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ..... WARD) + 14

2-FULL NAME James M Carson

(Residence in Baltimore: No. 7 days in Hospital St.: .....yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 15, 1868.
(Month) (Day) (Year)

7-AGE, 49 yrs. 8 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Wm A. Carson

11-BIRTHPLACE OF FATHER (State or Country), S.C.

12-MAIDEN NAME OF MOTHER Mary McElhenney

13-BIRTHPLACE OF MOTHER (State or Country), S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C J Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 5 1917, to October 11 1917, that I saw h in alive on October 11 1917, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

Intestinal perforation - Amoebic(?) with multiple abscesses of liver. now

..... (Duration) yrs. 1 mos. 2 2 ds.

CONTRIBUTORY (Secondary) Operation

..... (Duration) yrs. mos. ds.

(Signed) Robt. R. Reid M. D.

Oct. 11, 1917. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Kershaw S.C.

19-PLACE OF BURIAL OR REMOVAL, Kershaw S.C.

DATE OF BURIAL, Oct 11, 1917.

20-UNDERTAKER Hilbert & Sulz

ADDRESS 221 N Broadway

Spec.—8-24-14—M. & T.—3000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 Covington ST.: 24 WARD) REGISTERED NO. C 137 ✓

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace M. Kyle

(Residence in Baltimore: No. 1839 Covington St.; 2 yrs., mos. ds.)

D 9159

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. September 7, 1893 (Month) (Day) (Year)

7-AGE. 25 yrs. 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

X 037

9-BIRTHPLACE. (State or Country), Ohio

PARENTS.

10-NAME OF FATHER. Frank Clapper

11-BIRTHPLACE OF FATHER (State or Country). Ohio

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Kyle

(Address) 1839 Covington

15-

Filed ....., 191.....

HARRY O. ANDREWS
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27, 1917, to Oct 11, 1917, that I saw h[illegible] alive on Oct 11, 1917, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Child birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Puerperal Peritonitis

(Duration) yrs. 10 mos. ds.

(Signed) R. S. K. Campbell M. D.

Oct 11, 1917. (Address) 1644 Harlem

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lauverville Ohio — DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER Thos. Cook — ADDRESS 502 E North Ave

D 9160

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 9160

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Leadenhall St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph G. Dorr.

(Residence in Baltimore: No. 1112 Leadenhall St. St.: 38 yrs., 1 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, August 13th. 1879., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
38 yrs. 1 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, L. William Dorr.

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Louisa Bertram.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) May Dorr. (wife)
(Address) 1112 Leadenhall St.

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 10th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

Oct. 12, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Oct. 12, 1917

20-UNDERTAKER, J. Lew McCully — ADDRESS, 130 E. Fort Ave.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9161

CERTIFICATE OF DEATH.

104

D 9161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 E 28 North ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellsworth Raymond Forwood

(Residence in Baltimore: No. 618 E 28 North St.; ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 1st, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ellsworth R. Forwood

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Nellie Hobbs.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Forward

(Address) 618 E. Twenty Eighth St.

15-

Filed....., 191.....

Registrar.

OCT 12 1917 ROBERT R. KRAUTER Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 2nd 1917, to Oct 9th 1917, that I saw h.. alive on Oct 9th 1917, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Diarrh.

(Duration) ....yrs. ....mos. ....ds.

(Signed) Gwilym Stone M. D.

Oct 9th, 1917. (Address) 253 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pine Ridge Cemetery

DATE OF BURIAL, Oct. 12, 191..

20-UNDERTAKER George F. Reuth

ADDRESS 1735 Harford Ave.

D 9162

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

D 9162

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1911 Jefferson St. Ward 6)

REGISTERED No. C

2 FULL NAME William R. Heuer

(Residence in Baltimore: No. 1911 Jefferson St.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	White	single

6 DATE OF BIRTH: April (Month) 1 (Day), 1917 (Year)

7 AGE: yrs. 6 mos. 9 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto. md

PARENTS

10 NAME OF FATHER: William A. Heuer

11 BIRTHPLACE OF FATHER (State or country): Alma Wis.

12 MAIDEN NAME OF MOTHER: Nellie Shook

13 BIRTHPLACE OF MOTHER (State or country): Balto. md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William A. Heuer

(Address) 1911 Jefferson st.

15.

Filed OCT 12 1917, 191

ROBERT B. KRAUTH

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 10 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 5th, 1917, to. October 10th 1917, that I saw h~~e~~ alive on October 10th, 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cholera-infantis

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Frank J. Cook M. D.

Oct 10, 1917 (Address) 1937 E. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Oct 12, 1917

20 UNDERTAKER: Wm. J. Schaeffer & Son — ADDRESS: 516 Fremont St

State CAUSE OF DEATH in plain terms. ... certificate. ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9163

CERTIFICATE OF DEATH.

28 D 9163

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 S. Wolfe St. St.; W Ward) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Amrein

(Residence in Baltimore: No. 121 S. Wolfe St. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

Unknown 1

7-AGE, ... yrs. ..... mos. ..... ds.

38

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 043 040

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, John Amrein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Amrein

(Address) 121 S. Wolfe St.

15-

OCT 12 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 10th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct 10 1917, that I saw him alive on Oct 8 1917, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) J. B. Wash M. D.

Oct. 10, 1917. (Address) 1118 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct. 13, 1917
20-UNDERTAKER Tilly & Zeiler.	ADDRESS 403 S Wolfe St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9161 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9161

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1123 N. Caroline ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M. Kennedy

(Residence in Baltimore: No. 1123 N. Caroline St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, February 24, 1879
(Month) (Day) (Year)

7-AGE, 38 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Dettenthaler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore. Md.

12-MAIDEN NAME OF MOTHER Walburga Reckl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Kennedy

(Address) 1123 N. Caroline St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8 1917, to Oct. 11, 1917, that I saw h[illegible] alive on Oct. 11, 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct. 11, 1917. (Address) Chas. & Preston Sts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Oct. 15, 1917

20-UNDERTAKER Lilly & Zeile ADDRESS 4038 Norfolk

D 9165

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

D 9165

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 N Carey St. 16 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Inf of Willard & Theresa Allen

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: Oct (Month) 7 (Day), 1917 (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ? hrs. or ? min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) 1117 N Carey St

PARENTS

10 NAME OF FATHER Willard Allen

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Thekla Henson

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thekla Allen

(Address) .....

Filed OCT 12 1917, 191 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 9 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1917, to Oct 9 1917, that I saw her alive on Oct 9, 1917, and that death occurred, on the date stated above, at 6H 20M 30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
(about 5 or 6 months foetus)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maria Luther Engraver M. D.

....., 191 (Address) 2439 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: OCT 11 1917, 191

20 UNDERTAKER: Commissioner Health, — ADDRESS

WM. F. WOODALL

State CAUSE OF DEATH in plain terms. Technical or medical terms may be used, but the information is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9166 — 64 — D 9166

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Moore ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Norris

(Residence in Baltimore: No. 501 Moore St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day. ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 082

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Hilary Norris

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hamm

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Norris

(Address) 501 Moore St.

15-

OCT 12 1917 ROBERT B. KRAUSER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7th 1917, to Oct. 10th 1917, that I saw h[illegible] alive on Oct. 10th 1917, and that death occurred, on the date stated above, at 4 1/4 m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Jno. G. Schaller M. D.

Oct. 11, 1917 (Address) 1124 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Lebanon Cem. DATE OF BURIAL, Oct 12, 1917

20-UNDERTAKER Samuel I. Hensley ADDRESS 5 E. Biddle

Important: See instructions

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9167

CERTIFICATE OF DEATH

79

D 9167

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 807 Elder Alley ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 207 Elder alley. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Fem

4-COLOR OR RACE Blk.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Unknown, 1878
(Month) (Day) (Year)

7-AGE 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE (State or country) Frederick County- Md -

PARENTS

10-NAME OF FATHER Abraham Makell

11-BIRTHPLACE OF FATHER (State or country) Frederick Co- Md.

12-MAIDEN NAME OF MOTHER Susan Norris

13-BIRTHPLACE OF MOTHER (State or country) Frederick Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Smith

(Address) 207 Elder Alley.

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH October 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 9, 1917. to Oct- 11 1917.

that I saw h er alive on Oct- 11 .191 7.

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency with loss of compensation

(Duration) yrs. 2 mos. 14 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Bertha E. Tapman M. D.

Oct- 12, 191 7 (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Carmel Cem. DATE OF BURIAL Oct 12, 1917

20-UNDERTAKER Samuel Hemsley ADDRESS 5 Sw Biddle

state CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9163 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9163

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 60 Darby St. ST.; 43 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn E. Boston

(Residence in Baltimore: No. 60 Darby St. St.; .....yrs., 9 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, December (Month) 20th (Day), 1916 (Year)

7-AGE, ...yrs. 9 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Geo. Boston

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Blanch E. Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H. Boston

(Address) 60 Darby st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 9th 1917, to Oct. 11th 1917, that I saw her alive on Oct 10th 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary (Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration).....yrs.....mos.....ds.

(Signed) Geo E. Cross M. D.

10/11/17, 191... (Address) 1000 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem.	Oct. 13., 191..
20-UNDERTAKER Thomas H. Jones	ADDRESS 547 Chestnut

Spec.—8-24-14—M. & T.—2000 Bks.

D 9169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2633 Brnard (St.; 17 Ward) REGISTERED No. C

2-FULL NAME Charles E Brwer

(Residence in Baltimore: No. 2633 Brnard St.; yrs., mos. 13 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Sngle

6-DATE OF BIRTH, Sept (Month) 28 (Day), 1917 (Year).

7-AGE, yrs. mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, William E. Brwer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabth Cooprr

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabth Cooprr

(Address) 2633 Bernard st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 191 7, to Oct 11 191 7, that I saw h alive on Oct 11 191 7, and that death occurred, on the date stated above, at 1130A m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) 1 yrs. 1 mos. 2 ds.

(Signed) Prescott Knowlton M.D.

Oct 12, 191 7. (Address) 2438 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampstead — DATE OF BURIAL, Oct 12, 191 7.

20-UNDERTAKER Ehrmanths & Son — ADDRESS 367 Columbus

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9170

CERTIFICATE OF DEATH.

N 5 79

D 9170

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1323 Holbrook ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sally Rich

(Residence in Baltimore: No. 1323 Holbrook St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 27, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Joseph Rich

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sadie Ramsden

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Rich

(Address) 1323 Holbrook St.

15-

Filed OCT 12 1917, 191.... ROBERT B. KRAUTER
Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7th 1917, to Oct. 10th 1917, that I saw h— alive on Oct. 9th 1917, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

(a) Uraemia

(b) Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

Oct 11, 1917 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery

DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Presstman st.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9171 — D 9171

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 928 S. Sharp St. — WARD) 23

2-FULL NAME Elizabeth Land

(Residence in Baltimore: No. 928 Sharp St. — St. 35 yrs. ... mos. ... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH: Oct. (Month) 26th (Day) 1832 (Year)

7-AGE: 84 yrs. 11 mos. 16 ds. — If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE (State or country): Pa.

PARENTS

10-NAME OF FATHER: Ellwood Wilgus

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian Land

(Address) 928 S. Sharp St.

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5, 191 7, to, Oct 11 191 7, that I saw h[e] alive on Oct 11 191 7, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Congestion of the Lungs one

(Duration) ... yrs ... mos 6 ds.

Contributory (SECONDARY) .....

(Duration) ... yrs ... mos ... ds.

(Signed) Ethan B. Zug M. D.

Oct 11, 191 7 [Address] 624 Cathedral

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. — In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Pat. Olivet Cem. — DATE OF BURIAL: Oct. 13th 1917

20-UNDERTAKER: E. Schulman & Son — ADDRESS 1039 Hanover St

TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9172

CERTIFICATE OF DEATH.

+109 D 9172

1-PLACE OF DEATH Mercy Hospital

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Edward St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard F. Harrison Jr.

(Residence in Baltimore: No. Colgate, Md St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ...Nov... (Month) 3 (Day), 1917. (Year)

7-AGE, ...yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), U.S.

PARENTS.

10-NAME OF FATHER, Howard F Harrison

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret May Hill

13-BIRTHPLACE OF MOTHER (State or Country), U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Harrison

(Address) Colgate Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 12 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 191 7, to Oct 10 191 7, that I saw h im alive on Oct 12 191 7, and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

.....Intussusception.....

.....

.....

..... (Duration)...yrs...mos...ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)...yrs...mos...ds.

(Signed) Edward D. Lunsford M. D.

....., 191... (Address) Manchester

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos. 1 ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Colgate Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Oct 12, 1917.

20-UNDERTAKER	ADDRESS
John A Moan	Bank Lawn Md

Spec.—5-19-13—M. & T.—500 Bks.

D 9173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1720 D 9173

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 W Pratt ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Garbacher

(Residence in Baltimore: No. 1522 W Pratt St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 11 (Day), 1861 (Year)

7-AGE, 56 yrs. 7 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Mfr

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Conrad J Garbacher

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Margaret Hauptlein

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl D Garbacher

(Address) 1522 W Pratt

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22 1917, to Oct 11 1917, that I saw him alive on Oct 11 1917, and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis ?
& Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Incomplete Coma

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Dr. Theo Koerwer M. D.

Oct 12, 1917 (Address) 34 So Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, Oct 15, 1917

20-UNDERTAKER Geo J. Smith Co

ADDRESS 1111 W Fayette

OCT 12 1917

Spec.—8-24-14—M. & T.—2000 Bks.

Lem. Kaczynski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9171

CERTIFICATE OF DEATH.

104 D 9171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 S. Bond ST.: 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Kaczynski

(Residence in Baltimore: No. 834 S. Bond St.: ....yrs.,....mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. October 2, 1917. (Month) (Day) (Year)

7-AGE. ....yrs....mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Adam Kaczynski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Kadz Kaczynska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Kaczynski

(Address) 834 S. Bond St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 11 1917, to October 11 1917, that I saw him alive on October 11 1917, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

.....

.....

Convulsions

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Indigestion

..... (Duration) ....yrs. ....mos. 3 ds.

(Signed) L. Tanowitz M. D.

October 12 1917. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Oct 12, 1917
20-UNDERTAKER	ADDRESS
Wm Frankowski	40 Canton

Spec.—8-24-14—M. & T.—2000 Bks.

D 9175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 9175

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Burgess

(Residence in Baltimore: No. 1842 Druid Hill Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, ..., 1884
(Month) (Day) (Year)

7-AGE, 73 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter 070
(b) General nature of industry, business, or establishment in which employed (or employer): Drug store

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Stephen Burgess

11-BIRTHPLACE OF FATHER (State or Country), Washington DC

12-MAIDEN NAME OF MOTHER Mary Grey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thompson

(Address) 1842 Druid Hill Ave

15-

Filed....., 191.....
Registrar.

OCT 12 1917 ROBERT R. KRAUTER Special Patrolman

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1917, to Oct. 10 1917, that I saw him alive on Oct 10 - 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis peritonitis

(Duration) ....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ....yrs.....mos. 1 ds.

(Signed) Wm Hafle M. D.

Oct 10, 1917 (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos. 7 ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1842 Druid Hill Ave

19-PLACE OF BURIAL OR REMOVAL, Mt Zion

DATE OF BURIAL, Oct 12, 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 2 Lacy

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9176 51 D 9176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Martin Deponai

(Residence in Baltimore: No. 2204 N. Calvert St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Feb 28, 1871 (Month) (Day) (Year)

7-AGE. 46 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Newspaper Editor
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country). Washington D C.

PARENTS.

10-NAME OF FATHER. Martin John Deponai

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Kuhl

13-BIRTHPLACE OF MOTHER (State or Country). ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address) Broadway & Monument Sts.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 1917, to Oct 11, 1917, that I saw h[im] alive on Oct 11, 1917, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas Coccus

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) C. F. Balcheat M. D.

....., 191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 70 yrs. mos. ds.

Where was disease contracted, if not at place of death? Ct home

Former or usual residence 2204 N. Calvert

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 11, 191 7

20-UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9177 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hospital REGISTERED NO. C 104

CITY OF BALTIMORE: (No. ..... ST.: East WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Page

(Residence in Baltimore: No. 5 N. Exeter St De Hospital 4736 St.; yrs., 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. July 6, 1912 (Month) (Day) (Year)

7-AGE. yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Robert Preston

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER May Page

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Grafton

(Address) J. H. Hospital

15-

Filed Oct 11, 1917 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1917, to Oct 11, 1917, that I saw h[illegible] alive on Oct 11, 1917, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis and
Pyelitis from Chronic
Appendicitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Rosenau M. D.

Oct. 11, 1917. (Address) J. H. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. 1 mos. 19 ds. In the State 4 yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5 N. Exeter St (De Hospital 4736)

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER, F. B. Hepburn ADDRESS W 36 Fredk Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 9178

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 W Montgomery ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Parker

(Residence in Baltimore: No. 123 W. Montgomery St.: 15 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day) 1847 or so (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. A. Brown & Son

(Address) 108 W. Montgomery

15- OCT 13 1917 ROBERT R. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11 (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from May, 191, to Oct 8 1917, that I saw h— alive on Oct 8 1917 and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Edema Valvular Cor

(Duration) yrs. mos. ds.

(Signed) L. A. Warren M. D.

Oct 12, 1917. (Address) 522 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct

DATE OF BURIAL, Oct. 13, 1917

20-UNDERTAKER L. A. Brown & Son

ADDRESS 108 W Montg

Spec.—8-24-14—M. & T.—2000 Blks.

D 9179 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 9179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 W. Monty ST.; 77 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Faulkner

(Residence in Baltimore: No. 1432 W. Monty St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... Unknown ....., 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer 046
(b) General nature of industry, business, or establishment in which employed (or employer) ..... for [illegible]

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. L. Rodgers

(Address) South Boston Va

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1917, to Oct 11 1917, that I saw h[illegible] alive on Oct 10 1917, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows: Stomach T.B.

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Dr. Thomas

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) [illegible] M. D.

Oct 11, 1917 (Address) 712 S Brunswick

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pine Grove, Halifax Va

DATE OF BURIAL, Oct 13, 191...

20-UNDERTAKER L. L. Brown & Son

ADDRESS [illegible] Front

Bad O R R South Boston Halifax Co Va

Spec.--8-24-14—M. & T.--2000 Blks.

D 9180

HEALTH DEPARTMENT—CITY OF BALTIMORE

109 D 9180

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Whitney Irvin

(Residence in Baltimore: No. Harford Road Westfield Ave Hamilton St.; 7 yrs., 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 27, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, David Vernon Irvin

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Florence Isabel Whitney

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Florence Irvin

(Address) Harford Road West fieldave.

15-

Filed....., 191.....
Registrar.

OCT 13 1917 ROBERT R. KRAUTER Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 191 7, to Oct 12 191 7, that I saw h.. alive on Oct 12 191 7, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Catarrh

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. T. Eshleman M. D.

....., 191... (Address) Harwood Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 7 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Local

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	....., 191.7.
20-UNDERTAKER John J. Cowan & Son	ADDRESS 907 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

D 9181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 9181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 McElderry St.; 7th WARD) REGISTERED NO. C.....

2-FULL NAME Wm W. Wrightson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2319 McElderry St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 19 (Day), 1871 (Year)

7-AGE, 46 yrs. 3 mos. 23 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 840

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John B Wrightson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Russell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Wrightson

(Address) 2319 McElderry St

15-

OCT 13 1917

Filed....., 191.... ROBERT B. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Oct 12 1917, that I saw him alive on Oct 11 1917, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(Duration) ....yrs. 1 mos.....ds.

(Signed) Edward J. Cook M. D.

10/12, 1917. (Address) 413 N Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Oct 15, 1917
20-UNDERTAKER Henry Hoen Son	ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9182

CERTIFICATE OF DEATH.

151 D 9182

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 W Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Gurinsky

(Residence in Baltimore: No. 606 W Lombard St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Oct (Month) 11 (Day), 1917 (Year)

7-AGE, ...yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer): None -

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Gurinsky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Makos.

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Gurinsky

(Address) 606 Lombard St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 11 1917 to Oct 12 1917, that I saw h[illegible] alive on Oct 12 1917, and that death occurred, on the date stated above, at 5 [illegible]m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration) ....yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Prematur birth

(Duration) ....yrs. .... mos. 2 ds.

(Signed) M. C. Friedenwald M. D.

10/12, 191.. (Address) 612 Cole Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Oct. 13., 1917.

20-UNDERTAKER John Grabliauckas — ADDRESS 425 S. Paca St.

OCT 13 1917 ROBERT R. KRAUTER

BURIAL PERMIT

D 9183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9183

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 537 Gold ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Virginia Sparks

(Residence in Baltimore: No. 537 Gold St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, Oct. 10, 1917 (Month) (Day) (Year)

1887 C

7-AGE, 21 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): 070

8 97

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Alfred Talson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Sharkey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Talson

(Address) 537 Gold

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chd. & Hiprem

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

Oct 13, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State None yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Oct. 13, 1917.

20-UNDERTAKER James H Dennis

ADDRESS 1303 Eastman Av

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9187

CERTIFICATE OF DEATH.

104 D 9187

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomia Ruff Brown

(Residence in Baltimore: No. 2506 E Biddle St.: 1 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. ..... Aug (Month) 28 (Day), 1916 (Year)

7-AGE. 1 yrs. 1 mos. 14 da. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elizabeth Ruff

13-BIRTHPLACE OF MOTHER (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ruff

(Address) 2506 E Biddle

15-

OCT 13 1917 ROBERT B. KRAUTER

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1917, to Oct 11 1917, that I saw h[illegible] alive on Oct 11 1917, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ..... yrs. ..... mos. 7 da.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(Duration) ..... yrs. ..... mos. 1 da.

(Signed) William D. Ruark M. D.

Oct 12, 1917. (Address) 2506 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lehnards Cem	Oct 13, 1917
20-UNDERTAKER. John Herwig & Co	ADDRESS 2005 Bloom St

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9185 — 81 D 9185

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1532 N. Fulton Av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manassa Fogle

(Residence in Baltimore: No. 1532 N. Fulton Av. St.; X yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M.

4-COLOR OR RACE: W^te

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec (Month) 2nd (Day), 1864 (Year)

7-AGE: 52 yrs. 9 mos. 7 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Ref. Bkpr-ingper
(b) General nature of industry, business, or establishment in which employed (or employer): 011

9-BIRTHPLACE (State or country): Taneytown Carroll Co. Md.

PARENTS

10-NAME OF FATHER: Joseph Fogle

11-BIRTHPLACE OF FATHER (State or country): Carroll Co. Md.

12-MAIDEN NAME OF MOTHER: Rachel Reed

13-BIRTHPLACE OF MOTHER (State or country): Carroll Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Louisa C. Fogle

(Address) 1532 N Fulton Av

15- Filed ....., 191..... REGISTRAR

OCT 13 1917 ROBERT R. KRAUTER

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 10th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug, 1913, to Oct 10, 1917, that I saw h^m alive on Oct 10th 1917, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Contracted Kidneys, Tachycardia & Dropsy

(Duration) 4 yrs ..... mos ..... ds.

Contributory (SECONDARY) Oedema of Lungs

(Duration) ..... yrs ..... mos. 2 ds.

(Signed) E.L. Smith M. D.

Oct 10 1917 [Address] 1605 N Mont Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Oct 13 1917

20-UNDERTAKER: Josiah Seyfert — ADDRESS: 1600 N North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Delany

(Residence in Baltimore: No. ..... St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Oct 4, (Month) (Day) 1845 (Year)

7-AGE, 72 yrs. mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Denis Madigan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Johanna Oneight

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 12th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No record 191, to 191,

that I saw h[illegible] alive on Oct 12 191 7,

and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Dropsy

..... (Duration).....yrs.....mos.....ds.

(Signed) F. A. Warner M. D.

Oct 12, 1917. (Address) 1133 Valley st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 7 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER, Robt J. Turner — ADDRESS 1712 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 9187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9187

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schuerman

(Residence in Baltimore: No. 120 S Washington St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, September 23, 1877
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Schuermann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Ruch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margreth Eshander

(Address) 126 S. Washington

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Filed....., 191.....
Registrar.

OCT 13 1917 ROBERT E. KRAUSER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1917, to Oct 13 1917, that I saw h[illegible] alive on Oct 16 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) ....yrs. ....mos. 3 ds.

(Signed) H Meskel M. D.

Oct 13, 1917. (Address) St Joseph Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Paul (Schmutz)

DATE OF BURIAL, Oct 15 1917

20-UNDERTAKER Wendel & Appel

ADDRESS 328 Mun

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9183

CERTIFICATE OF DEATH.

81 D 9183

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Brentwood ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Keaver

(Residence in Baltimore: No. 1117 Brentwood Ave St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, February 6, 1835
(Month) (Day) (Year)

7-AGE, 82 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James McClary

11-BIRTHPLACE OF FATHER (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER Julia Crouse

13-BIRTHPLACE OF MOTHER (State or Country), Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. George Deaver

(Address) 1117 Brentwood St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2, 191 7, to October 11, 191 7, that I saw h 2 alive on " " 191 7, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as followa:

Uterus-Sclerosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Edema

(Duration) 2 yrs. 3 mos. ds.

(Signed) Hugo H. Hartman M. D.

Oct 13, 191 7. (Address) 1121 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct. 13, 191 7

20-UNDERTAKER William Cook — ADDRESS 502 E. North

OCT 13 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9189 D 9189

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kellum

(Residence in Baltimore No. 1726 Orleans St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colo

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June ; 1 ..... (Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Kellum

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susan Palmer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Campbell

(Address) 1726 Orleans St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1917, to Oct. 11 1917, that I saw h ~~im~~alive on Oct. 10, 1917, and that death occurred, on the date stated above, at 5 a, m.

The CAUSE OF DEATH* was as follows: Phthisis Pulmonalis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) H. K. Adkins M. D.

10/11/17 (Address) 520 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Tiffers Wharf North — DATE OF BURIAL, Oct. 14, 1917

20-UNDERTAKER Thumblond & Wm — ADDRESS 506 East Pl

Mrs M A Elliott

Spec.—8-24-14—M. & T.—2000 Bks.

D 9190 D 9190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH St. Vincents Inf Asylum

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Denning

(Residence in Baltimore: No. 1401 Division St.; ..... yrs., ... mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	X

6-DATE OF BIRTH, Oct (Month), 7th (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. 5 ds.	.... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 000
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. P. Kavanaugh

(Address) St. Vincents Inf Asy

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7th 1917, to Oct 12th 1917, that I saw h-~~e~~ alive on Oct 12th 1917, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

1 Birth - Premature - 7½ mo. Twin
Exemption - Underdeveloped - &
Malnutrition (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward M.C. Parker M. D.

....., 191... (Address) 111 E. Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem	Oct 13..., 1917

20-UNDERTAKER	ADDRESS
M Tahey & Sons	508 Lafayette Ave

Spec.—5-19-13—M. & T.—500 Bks.

D 9191 D 9191

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 S Spring ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Carrie Davis

(Residence in Baltimore: No. 210 S Spring St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, May (Month) 17 (Day), 1881 (Year)

7-AGE, 36 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Edward Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Bessy Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alberta Williams

(Address) 210 S. Spring St.

15-

Filed....., 191.... Registrar.

l-S-P.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1915, to Oct 12 1917, that I saw her alive on Oct 11 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Richard L. Eastman M. D.

Oct 12, 191 (Address) 1514 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 13, 191

20-UNDERTAKER Samuel Handley

ADDRESS 5 Bon Secours

OCT 13 1917 ROBERT R. KRAETER

D 9192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9192

CERTIFICATE OF DEATH.

X 175

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Martin

(Residence in Baltimore: No. Harrisonville, Balto Co, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) January (Day) 1 (Year) .....

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Automobile
(b) General nature of industry, business, or establishment in which employed (or employer)..... Owner

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, G. Frank Martin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eugenia Harker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. M. Tickner

(Address) North Pearre

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October (Month) 11, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following internal injuries
Caused by his automobile turning
over his body when he crashed into a
tree was in gear accidentally

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Donoghue M. D.
(Coroner.)

Oct 17, 1917. (Address) 3127 Ourlady Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Chapel	Oct 19 1917
20-UNDERTAKER	ADDRESS
W. J. Tuckerman	North Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9193

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9193

CERTIFICATE OF DEATH.

115

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 McDonough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Mahone

(Residence in Baltimore: No. 930 McDonough St. 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	a.a	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Stephen Mahone

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ella Fawlkes

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wife .....

(Address)... 930 McDonough .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1917, to Oct. 12, 1917, that I saw h[illegible] alive on Oct. 11, 1917, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Hepatic Abscess

.....

.....

Dysentery (Duration)..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Dysentery

..... (Duration)..... yrs. ..... mos. 28 ds.

(Signed) J. C. Kline M. D.

10/12, 1917. (Address) 1520 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Prince Edward Cem. DATE OF BURIAL, Oct 17, 1917.

20-UNDERTAKER A. C. Cook ADDRESS 1405 McElderry

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9191

CERTIFICATE OF DEATH.

D 9191

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 Chestnut Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie M Shue

(Residence in Baltimore: No. 3507 Chestnut Av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 17, 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Joseph Steil

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER Maria Keney

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. F. M. Shue

(Address) 3507 Chestnut Av

15-

Filed ....., 191.....
Registrar.

OCT 13 1917 BORIS E. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11th, 1917.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Oct 11th 1917, that I saw her alive on Oct 11 1917, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

..... (Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary) Multiple

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A Nowaitz, M. D.

Oct 12, 1917. (Address) 865 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Oct 15, 191...

20-UNDERTAKER H. S. Mac Hall

ADDRESS 2539 Pall Mall

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9195

CERTIFICATE OF DEATH.

D 9195

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Eyler

(Residence in Baltimore: No. 5313 Main St. Arlington. Balto Co. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 22 (Day), 1908 (Year)

7-AGE, 9 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Scholar
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jos. E. Eyler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary E. Childs

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos E Eyler

(Address) 5313 Main St Arlington

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull, Caused by falling out of tree, (accidental)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration) .....yrs.....mos.....ds.

(Signed) C. L. Lescale M. D.
(Coroner)

Oct 13, 191 . (Address) 512 Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cem. DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER H S Marshall ADDRESS 1539 Pitt Road

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 120 D 9196

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Rachel Zink

(Residence in Baltimore: No. Church Home & Infirmary St.; ...yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, January (Month) 1st (Day), 1844 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 9 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany, Maryland

PARENTS.

10-NAME OF FATHER, John Caspar Zink

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Hampden

13-BIRTHPLACE OF MOTHER (State or Country), Kent Island, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Church Home & Infirmary

15-

Filed....., 191.....

Registrar.

OCT 13 1917 ROBERT R. KEATOR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1917, to Oct 11 1917, that I saw h[illegible] alive on Oct 8 1917, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia,
Chronic Nephritis
Myocardial degeneration

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ... yrs. ... mos. 10 ds.

(Signed) W H Fuller M. D.

10/11, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 13 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Govans Md

19-PLACE OF BURIAL OR REMOVAL, Presbyterian Cemetery, Govans — DATE OF BURIAL, Oct 13, 1917

20-UNDERTAKER H C Kingdon — ADDRESS 175 Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9197

CERTIFICATE OF DEATH.

D 9197

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Gardina

(Residence in Baltimore: No. Mercy Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, 10 (Month) 1 (Day) 1917 (Year)

7-AGE,	If LESS than 1 day,
0 yrs. 0 mos. 0 ds.	hrs. 30 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Vincent Gardina

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Catherine Leher

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 1 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-1 1917, to 10-1 1917, that I saw h[illegible] alive on 10-1 1917, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

1. Congenital Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

(Signed) A. C. Warnekros M. D.

10-1, 1917 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT 12 1917 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

OCT 12 1917 ROBERT R. CARTER

per Wm E. KENDALL

D 9193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9193

175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~[illegible]~~ 13 Ward Hospital WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Von Brokern,

(Residence in Baltimore: No. 503 Saratoga St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Mas	colr	Mard

6-DATE OF BIRTH, ...Feb.... (Month) ....6.... (Day) 1853 (Year)

7-AGE, ...64.... yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....Watchman.... 067
(b) General nature of industry, business, or establishment in which employed (or employer) ....Ho House....

9-BIRTHPLACE, (State or Country), ...Balt....

PARENTS.

10-NAME OF FATHER ....John Von Brokern,....

11-BIRTHPLACE OF FATHER (State or Country), ...Holland....

12-MAIDEN NAME OF MOTHER ....Anna Kern....

13-BIRTHPLACE OF MOTHER (State or Country), ...~~Balt~~ Holland....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....Jno. H. Von Brokern....

(Address) ....1814 E. Lombard St....

15-

Filed ....OCT 13 1917...., 191....

ROBERT R. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Oct.... (Month) ....11.... (Day), 191.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....Inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....Inquest.... (Inquest, autopsy or inquiry) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

....Pneumonia....
....Shock by Accident....
.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .... (Secondary)
.... (Duration) ....yrs. ....mos. ....ds.

(Signed) ....Wm. H. Von Brokern.... M. D. (Coroner)

Oct 13, 191.7 (Address) ....W. Eden St....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....Life.... yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....Falls Road....

Former or usual residence ....

19-PLACE OF BURIAL, OR REMOVAL, ...Oak Lawn Cem.... DATE OF BURIAL, ...Oct 15.... 191.7

20-UNDERTAKER ....Libby & Zeller.... ADDRESS ....1107 Dillon St....

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9199

CERTIFICATE OF DEATH.

92 D 9199

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1192 Schroeder St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luke O Rourke

(Residence in Baltimore: No. 1192 Schroeder St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) ..... (Day) ....., 1837 (Year)

7-AGE. 80 yrs. 3 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Wm O Rourke

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Rosanna Mulvey

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary O Rourke

(Address) 1192 Schroeder St

15-

Filed....., 191.....

Registrar.

OCT 13 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 12 1917, that I saw h in alive on Oct 12 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

1. Lobar Pneumonia

.....

.....

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs....mos....ds.

(Signed) J. A. Sullivan M. D.

10-12, 1917 (Address) 1192 Schroeder St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Oct 15, 1917

20-UNDERTAKER John A Moran

ADDRESS Bank & Dames Sts

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9200 D 9200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 453

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Hoover

(Residence in Baltimore: No. Johns Hopkins Hosp. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	single

6-DATE OF BIRTH, November 25, 1908
(Month) (Day) (Year)

7-AGE, 8 yrs. 10 mos. 20 ds. — If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albert A. Hoover

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anne Cochran

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

OCT 13 1917 ROBERT P. GRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 14 1917 to October 13 1917, that I saw him alive on October 13 1917, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Acute lymphatic leukemia

(Duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B. Conrad M. D.

Oct. 13, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 30 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Cumberland, Md.

19-PLACE OF BURIAL OR REMOVAL, Cumberland Md — DATE OF BURIAL, Oct. 16, 1917.

20-UNDERTAKER 221 N Broadway — ADDRESS 221 N Broadway

D 9201

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 9201

CERTIFICATE OF DEATH

61

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1411 Ramsay ST.: 19 WARD)

(if death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine E Fleisch

(Residence in Baltimore: No. 1411 Ramsay St.; yrs. 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: White

5-SINGLE MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: Aug (Month) 4 (Day), 1917 (Year)

7-AGE: yrs. 2 mos. 8 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE (State or country): Balto. md

PARENTS

10-NAME OF FATHER: Joseph Fleisch

11-BIRTHPLACE OF FATHER (State or country): Balto md

12-MAIDEN NAME OF MOTHER: Augusta Mayer

13-BIRTHPLACE OF MOTHER (State or country): Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph E Fleisch

(Address) 1411 Ramsay St

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11, 191..., to, Oct 12 1917, that I saw her alive on Oct 12 1917, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

over.

Cerebral Meningitis

(Duration) ..... yrs ..... mos. 2 ds.

Contributory (SECONDARY)

(Duration) ..... yrs ..... mos. ..... ds.

(Signed), J Harry Boyd M. D.

Oct 13, 1917 [Address] 612 Columbia

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Oct 15 1917

20-UNDERTAKER: Geo Leimbach & Son

ADDRESS: Cor Wash

TION is very important. See instructions on back

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9202 64 D 9202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 310 E. Madison St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. Morris

(Residence in Baltimore: No. 310 E. Madison St. 27 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Nov. (Month) 14 (Day), 1855 (Year)

7-AGE: 61 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Cumb. Ohio

PARENTS.

10-NAME OF FATHER: Geo. Morris

11-BIRTHPLACE OF FATHER (State or Country): England

12-MAIDEN NAME OF MOTHER: Julia A. McDonald

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Morris

(Address) 310 E. Madison St.

15-

Filed ....., 191.....

Registrar.

OCT 11 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27 1917, to Oct. 10 1917, that I saw her alive on Oct. 10 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever (Central)

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hardening of the Arteries

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct. 11, 1917 (Address) 8 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds. Born

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, 10/12, 1917

UNDERTAKER J. A. Fulpatrick — ADDRESS 243 W. North Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9203

CERTIFICATE OF DEATH.

40

D 9203

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 E Fayette ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H Huggins Sr

(Residence in Baltimore, No. 2124 E Fayette St.; ___ yrs., ___ mos. ___ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Jan 31, (Month) (Day) 1841 (Year)

7-AGE, 76 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fabric Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Martin 030.

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John T. Huggins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Dare.

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate E Huggins

(Address) 2124 E Fayette St

15-

Filed....., 191.....

Registrar.

OCT 14 1917 HARRY O. SAUERS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 8 1917, to Oct. 11 1917, that I saw h... alive on Oct. 10 1917, and that death occurred, on the date stated above, at 5:55 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Chronic (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bright's Disease (Duration) ... yrs. 6 mos. ... ds.

(Signed) P. C. Dean M. D.

Oct 12, 1917. (Address) 2600 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cat Lawn Cemetery

DATE OF BURIAL, Oct. 14, 1917.

20-UNDERTAKER Elliott E Fuller

ADDRESS 231 N Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

D 9201

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9201

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 Mondawmin Ave St.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Isaacs

(Residence in Baltimore: No. 2327 Mondawmin Ave St.; 44 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 3rd (Day) 1848 (Year)

7-AGE, 69 yrs. 8 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs K Isaacs

(Address) 2327 Mondawmin Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 7th 1915, to Oct. 13th 1917, that I saw h[illegible] alive on Oct 13th 1917, and that death occurred, on the date stated above, at 2 o'c A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 20 yrs. — mos. — ds.

(Signed) Louis P Hamburger M. D.

Oct. 13th, 191.7 (Address) 1207 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto (Cedar) — DATE OF BURIAL, Oct 15, 191.7

20-UNDERTAKER Bard & Sondheim — ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

9205 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9205

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 Buckhead St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Simmons

(Residence in Baltimore: No. 120 Buckhead St.: 69 yrs., 5 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 18, 1848 (Month) (Day) (Year)

7-AGE, 69 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Straton.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dallas

(Address) 120 Buckhead

15-

OCT 14 1917 EARLE O. ANDREWS

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 9 1916, to Oct 13 1917, that I saw her alive on Oct 13 1917, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

10/15/17, 1917. (Address) 129 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, 10/15, 1917

20-UNDERTAKER L. Fen McCully ADDRESS 130 E. Fort

D 9206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 D 9206

1-PLACE OF DEATH

CITY OF BALTIMORE (No. East of Wolfe St. 6 ST.: WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard W Adams

(Residence in Baltimore: No. 135 N Broadway ST.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 7 (Day) 1868 (Year)

7-AGE, 49 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). O/H

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas. A. Adams

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Francis E. Grebb

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas R Adams

(Address) 620 E. 34th St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.)
I find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Sherry Dye W Trust Co M. D.
(Coroner.)
9/13, 191.. (Address) 760 E Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 15, 1917

20-UNDERTAKER Graham F Walker — ADDRESS 723 Wharf Ave

Important. See instructions on back of certificate.

D 9207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9207

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2411 W Franklin ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Jordan

(Residence in Baltimore: No. 2411 W Franklin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: April 25, 1849 (Month) (Day) (Year)

7-AGE: 68 yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: William Spicer

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel E. Lubelman

(Address) 2411 W Franklin St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chronic Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(Duration) suddenly yrs. mos. ds.

(Signed) James M Fowler M. D.
(Coroner)

Oct 15 1917. (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 15 1917

20-UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9203 D 9203

CERTIFICATE OF DEATH.

1 104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2802 Hilldale Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Nelson Jenkins

(Residence in Baltimore: No. 2802 Hilldale Ave St.; Life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 11, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Arthur Nelson

11-BIRTHPLACE OF FATHER (State or Country), Camden NJ.

12-MAIDEN NAME OF MOTHER Elsie allison

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Jenkins

(Address) 2802 Hilldale Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 13 1917, that I saw h.. alive on Oct 13 1917, and that death occurred, on the date stated above, at 11 4 m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) Inability to retain food

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) John A Evans M. D.

Oct 13, 1917 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Pk

DATE OF BURIAL. Oct 15, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 E Mott

Dr. John - Evans Carey & Fayette

Spec.—5-19-13—M. & T.—500 Bks.

D 9203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9203

1-PLACE OF DEATH Skin + Cancer Hospt. REGISTERED NO. C

CITY OF BALTIMORE: (No. 2510 Greenmount Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Steinbock

(Residence in Baltimore: No. 2047 E. North Ave. St.; 44 yrs., 10 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov. 2d, 1872 (Month) (Day) (Year)

7-AGE, 44 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John Casson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Annie E. Blackburn

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Deaver

(Address) 2047 E. North Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16th 1917, to October 13 1917, that I saw h[illegible] alive on Oct 12th 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma Uteri

2.

3. (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo. W. Cowen M. D.

Oct. 13th, 1917. (Address) 1000 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 4 mos. 25 ds. In the State yrs. 44 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2047 E North Ave

19-PLACE OF BURIAL OR REMOVAL, St. Johns - Waverly

DATE OF BURIAL, Oct. 15, 1917

20-UNDERTAKER Wm Cook

ADDRESS 503 E North

D 9210 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9210

CERTIFICATE OF DEATH.

6

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1706 N Monford ave ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Cruddon

(Residence in Baltimore: No. 1706 N Monford ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) June (Day) 20, (Year) 17

7-AGE, ... yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER Edward Cruddon

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ella Beedom

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Cruddon

(Address) 1706 N Monford

15-

OCT 14 1917 HARRY D. JENKINS Burial Permit Clerk

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Oct (Day) 13, (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchitis Pneumonia

..... (Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) Measles

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

Oct 14, 1917. (Address) 711 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct 14, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 C North

Important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

9211 — 120 — D 9211

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 811 E. 34th St., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Vada Neilhardt

(Residence in Baltimore: No. 811 E 34th St., St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Unknown (Month), 1882 (Year)

7-AGE: 35 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Rev. C. M. Hott

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Arbelia C. Eyler

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. A. Hott

(Address) 811 E. 34th St

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21, 1916, to, Oct 12 1917, that I saw h[illegible] alive on Oct 12 1917, and that death occurred, on the date stated above, at 9.35 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Heart

(Duration) yrs 9 mos 12 ds.

Contributory (SECONDARY): nephritis

(Duration) 1 yrs mos ds.

(Signed), John D. Bubert M. D.

Oct 13, 1917 [Address] 48 St Paul 242 for

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Edmonds Md

DATE OF BURIAL: Oct 15, 1917

20-UNDERTAKER: David Easton

ADDRESS 516 [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D 9212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 W Montgomery ST.; 22 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Israel

(Residence in Baltimore: No. 626 W Montgomery St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, About 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Isaac Israel

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Bush

(Address) 640 Ham St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Oct 13 1917, that I saw h[im] alive on Oct 12 1917, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular disease

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Guy Bowley M. D.

10/14/, 191.7 (Address) 136 W Mad St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int Suburn Cemetery — DATE OF BURIAL, Oct 17, 191...

20-UNDERTAKER J. B. & H. Cooper — ADDRESS 1106 W Baltimore St

D 9213

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D 9213

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1919 Wilkens Ave ST.: 80 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Mary A. Buck

(Residence in Baltimore: No. 1919 Wilkens Ave St.: 45 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 18 (Day), 1852 (Year)

7 AGE: 65 yrs. 2 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Randallstown Md

PARENTS

10 NAME OF FATHER: Ephraim O. Sipes

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Frytogle

13 BIRTHPLACE OF MOTHER (State or country): Balto Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin F Buck

(Address) 1919 Wilkens Ave

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 12 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov —, 1916, to Oct 12 1917, that I saw h[er] alive on Oct 11, 1917, and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Cardiac Dilatation

(Duration) — yrs. 11 mos. — ds

Contributory (SECONDARY) Exhaustion

(Duration) — yrs. — mos. — ds.

(Signed) Howard Jacobs, M. D.

Oct 12, 1917 (Address) Marlborough Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Oct 15, 191.....

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 E Balto St

State CAUSE OF DEATH in plain English. Do not use abbreviations or initials. Do not report symptoms, but the disease causing death. Name the disease causing the fatal condition, not the mode of dying, such as heart failure, asphyxia, anemia, etc. It is very important. See instructions on back of certificate.

OCT 14 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 9214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.: Hd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Beam

(Residence in Baltimore: No. Maryland General Hosp St.: ..... yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	married

6-DATE OF BIRTH, July (Month) 15 (Day), 1896 (Year)

7-AGE, 21 yrs. 2 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clerk S. 009
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Western Maryland R.R.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. H. Beam

11-BIRTHPLACE OF FATHER (State or Country), Pikesville Md.

12-MAIDEN NAME OF MOTHER, Margaret L. Constantine

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Beam

(Address) Arlington Md.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4- 1917, to Oct 11 1917, that I saw h.m alive on Oct. 11. 1917, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. 1W ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Reisterstown Rd. Md

19-PLACE OF BURIAL OR REMOVAL, Stone Chapel Pikesville DATE OF BURIAL, Oct 13, 191...

20-UNDERTAKER Joseph B Cook ADDRESS 603 N Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9215 — 104 D 9215

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 A Donell ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wojtulewicz

(Residence in Baltimore: No. 2816 A Donell St ... Stay Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	single

6-DATE OF BIRTH, ~~May~~ April 30, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 13 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 000 .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Wojtulewicz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Alexandra Zandu

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Joseph Wojtulewicz .....

(Address) ..... 2816 A Donell St .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct ~~14~~ 13, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct ~~14~~ 191 , that I saw h[illegible] alive on Oct 13 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

..... Enteritis .....

.....

.....

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) 2938 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem — DATE OF BURIAL, Oct 15, 1917.

20-UNDERTAKER Stephen J Trakowski — ADDRESS 1052 Fenwick Ave

OCT 14 1917 — REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9216 D 9216

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E Fairmount Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Jantoff

(Residence in Baltimore: No. 2010 E Fairmount Ave St.; 25 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, September (Month) 15 (Day), 1853 (Year)

7-AGE, 64 yrs. — mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Walbarsch

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bennett Jantoff

(Address) 2010 E Fairmount Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1905, to October 14 1917, that I saw her alive on October 14 1917, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. ....mos. ....ds.

(Signed) R. K. D. Mengert M. D.

X. 15, 191.7. (Address) 2431 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Repose Blair Pk. | DATE OF BURIAL, Oct 15, 191.7.

20-UNDERTAKER S. Simmons & Bro | ADDRESS 1107 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9217

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Collins

(Residence in Baltimore: No. 1361 Calhoun St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, 1913.
(Month) (Day) (Year)

7-AGE, 5 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

OCT 17 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 6 1917 to October 12 1917, that I saw him alive on October 12 1917, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

tuberculous meningitis

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Margaret Tyler M. D.

Oct. 12, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1361 Calhoun St

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Oct. 15, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Presstman

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9218 (64)

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Fulton and Franklin St. 70 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. Eden

(Residence in Baltimore: No. Fulton and Franklin St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: March 29, 1835 (Month) (Day) (Year)

7-AGE: 82 yrs. 6 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): St Marys Co Md

PARENTS

10-NAME OF FATHER: Charles Taylor

11-BIRTHPLACE OF FATHER (State or country): St Marys Co Md

12-MAIDEN NAME OF MOTHER: Lyon Hallord

13-BIRTHPLACE OF MOTHER (State or country): St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E R Mensh Asst Supt

(Address) Fulton and Franklin

15- Filed ....., 191.... Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12, 1917, to Oct 13 1917,

that I saw h[illegible] alive on Oct 12 1917,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), [illegible] M. D.

Oct 14, 1917 (Address) 2109 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 10 yrs. ..... mos. — ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Home for the Aged McE Church

19-PLACE OF BURIAL OR REMOVAL: Green Mount — DATE OF BURIAL: Oct 15, 1917

20-UNDERTAKER: George J Smith — ADDRESS 1000 N Eutaw St

This CERTIFICATE is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 9219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Benson

(Residence in Baltimore: No. Calhoun & Lexington St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, Widow OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, June 24, 1828
(Month) (Day) (Year)

7-AGE, 89 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ella J. Jones

(Address) 1901 Madison Ave. Balto.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8 1917, to Oct. 13 1917, that I saw h[illegible] alive on Oct. 13, 1917, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Senility and exhaustion

..... (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Strangulated hernia

..... (Duration)....yrs....mos. 3 ....ds.

(Signed) W. T. Termeyer M. D.

....., 191... (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 6 ds. In the State....yrs. 7 mos....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Equal Rights Home

19-PLACE OF BURIAL OR REMOVAL, Old Christ Church Cemetery

DATE OF BURIAL, Oct. 15, 1917.

20-UNDERTAKER Eckhardt & McCleary George J. Smith

ADDRESS 1000 & 1002 Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.; 4 WARD)

REGISTERED No. C 4176

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin T. Phillips

(Residence in Baltimore: No. Univ. Hospt St.; yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 5, (Month) (Day) 1857. (Year)

7-AGE, 60 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086

4

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Samuel T. Phillips

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Lyda Ann Hartsock

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. J. Phillips Jr

(Address) 1810 Maryland Ave

15- OCT 15 1917

Filed....., 191.... HENRY A. ANDREAE Deputy Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 14 1917, that I saw him alive on Oct 14 1917, and that death occurred, on the date stated above, at 2.10 p m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) unknown ds.

CONTRIBUTORY (Secondary) Prostatectomy

(Duration) yrs. mos. ds.

(Signed) A. B. B. Brantley M. D.

Oct 14, 1917. (Address) Univ Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 17 ds. In the State yrs. life mos. ds.

Where was disease contracted, if not at place of death? unknown.

Former or usual residence Lakeville Md.

19-PLACE OF BURIAL OR REMOVAL, Mt Gates Point Md. DATE OF BURIAL, Oct 16, 1917.

20-UNDERTAKER Geo. W. Little ADDRESS 531 N Eutaw St

D 9221

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Registered No. C 39

CITY OF BALTIMORE (No. 1305 ~~Gilmor~~ St. 15 Ward) — (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alfonso Watkins

(Residence in Baltimore: No. 1305 N. Gilmor St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April 13, 1872 (Month) (Day) (Year)

7 AGE: 45 yrs. 5 mos. 29 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): 059

33

9 BIRTHPLACE (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Edward Watkins

11 BIRTHPLACE OF FATHER (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Lucy Moran

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie A. Watkins

(Address) 1305 N. Gilmor St.

15

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 14 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1917, to Oct 12 1917, that I saw h— alive on Oct 12, 1917, and that death occurred, on the date stated above, at 3:25 m.

The CAUSE OF DEATH* was as follows:

Cancer of left tonsil

(Duration) 1 yrs. — mos. — ds

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) Jno C Jenkins M. D.

Oct 14, 1917 (Address) 1327 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: Oct 16, 1917

20 UNDERTAKER: Geo N Little — ADDRESS: 531 N Fremont Ave

Make Certificate is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 9222

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Frederick Ave St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Brunier

(Residence in Baltimore: No. 2529 Frederick Ave St.; 30 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, April (Month) 18. (Day), 1860 (Year)

7-AGE, 57 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lard Refiner
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Louis Brunier

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hannah Disler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Brunier

(Address) 2529 Frederick Av

15-

OCT 15 1917 HARRY O. ANDREWS

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 12th (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 23 1917, to Oct 12th 1917, that I saw him alive on October 12 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Leukaemia & Hypostatic Congest.

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. W. Keown M. D.

Oct 18, 1917. (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER Chas J Wasmus

ADDRESS 217 W. Fulton Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D 9223

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 S. Luzerne ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Preston Harris

(Residence in Baltimore: No. 717 S Luzerne St.; ....yrs.. ....mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 25, 1901. (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Lee H. Harris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Grace M. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee H. Harris

(Address) 717 S. Luzerne Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12 1917, to Oct 14 1917, that I saw h.. alive on Oct 14 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Congenital debility

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Hannigan M. D.

Oct 14, 191.. (Address) 2413 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel

DATE OF BURIAL, Oct 15, 191..

20-UNDERTAKER H. Sander & Sons

ADDRESS 1210 Eutaw

9221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9221

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 N Monroe St. St., Ward 28) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sommerville

(Residence in Baltimore: No. 211 N Monroe St. St.; yrs., 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE. (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sommerville

(Address) 211 N Monroe

15-

Filed OCT 15 1917, 191 HARRY C. HAMBLETON Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 15 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Auburn Conn DATE OF BURIAL, Oct. 15, 1917

20-UNDERTAKER Harry A. Vodery ADDRESS 1726 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9225 42 D 9225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.: 10 Ward) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie E. Flynn

(Residence in Baltimore: No. 1046 Central Ave St.: 43 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 1 (Day) 1 (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Andrew Donohue

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Bridget Radigan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Mrs. F. Flynn

(Address) 1046 N. Central Ave

15-

OCT 15 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Oct 13 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and intestines

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H Markel M. D.

Oct 13, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 20 ds. In the State 43 yrs. mos. ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence 1046 N. Central Ave

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery Govans DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER Henry Horck Son ADDRESS 1309 E Eager St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9226 D 9226

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 S. Wolfe St. ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Glusak

(Residence in Baltimore: No. 722 S. Wolfe St.: yrs., 9 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, ... Jan. (Month) 2 (Day), 1905 (Year)

7-AGE, ... yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Stanislaw Glusak.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Rozalia Styz

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Glusak

(Address) 722 S. Wolfe St.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 14 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 7 191 7 to Oct 14 191 7, that I saw h alive on Oct 14 191 7, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .... yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) .... yrs. .... mos. 1 ds.

(Signed) A. J. Rosamond M. D.

Oct. 14, 191... (Address) 1600 Brookline Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, Oct. 15, 191..

20-UNDERTAKER William Frazier ADDRESS 1618 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9227

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tom Angola

(Residence in Baltimore: No. 429 S. Caroline St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, Not Known, 1907
(Month) (Day) (Year)

7-AGE, ..yrs. 10 mos. ..ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Anthony Angola

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Antonia Szerd

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Angola

(Address) 427 S. Caroline

15- Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1917, to Oct. 14 1917, that I saw him alive on Oct. 14 1917, and that death occurred, on the date stated above, at 4 45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis
(No other diagnosis can be ascertained)
(Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Dr. O
(Duration) yrs. mos. ds.

(Signed) Israel S. Strauss M. D.
Oct. 14, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 25 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 429 S. Caroline

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent — DATE OF BURIAL, Oct 15, 1917

20-UNDERTAKER Mt Hall Church — ADDRESS 1618 Eden

(Chas Tarpin)

D 9223 D 9223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 807 n Dallas St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Tarpin

(Residence in Baltimore: No. 807 n Dallas St., St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mat

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Baby

6-DATE OF BIRTH, Aug 22, 1901
(Month) (Day) (Year)

7-AGE, 6 yrs. 1 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Baby 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas Tarpin

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Rebecca Hanley

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Tarpin

(Address) 807 n Dallas

15-

Filed....., 191.....

Registrar.

OCT 15 1917 HARRY C. AA...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia,

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 16, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemitary — DATE OF BURIAL, Oct 15, 1917

20-UNDERTAKER Wm R A Elliott — ADDRESS 506 East-[illegible]

Important. See instructions on back of Certificate.

D 9229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 809 Unity St. 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Dorsey

(Residence in Baltimore: No. 809 Unity St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, 1
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Billie Semmes

(Address) 1307 E Madison St

15-

OCT 15 1917

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Oct 15 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER Jas R A Elliott

ADDRESS 506 East

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9230

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Williams

(Residence in Baltimore: No. 1632 W. Fayette St — St.: — yrs.. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. April 5th, 1881. (Month) (Day) (Year)

7-AGE. 36 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At her home

9-BIRTHPLACE, (State or Country), Massachusetts

PARENTS.

10-NAME OF FATHER. James M Benjamin

11-BIRTHPLACE OF FATHER (State or Country). Massachusetts

12-MAIDEN NAME OF MOTHER. Mary Oxford

13-BIRTHPLACE OF MOTHER (State or Country). Massachusetts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Rogers Williams

(Address) 1632 W. Fayette st

15- OCT 15 1917

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 12 1917. that I saw her alive on Oct 12 1917, and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Insufficiency

Aortic Insufficiency,

unknown

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

Pulmonary Edema (Duration) ....yrs. ....mos. 10 ds.

(Signed) Bernard Strauss M. D.

Oct 15, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State 3 yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1632 W Fayette St

19-PLACE OF BURIAL OR REMOVAL. Marley Burying Ground Jacksonville — DATE OF BURIAL. Oct 15, 1917.

20-UNDERTAKER Armstrong Denny Co — ADDRESS 715 Light st

Spec.—8-24-14—M. & T.—2000 Bks.

B 9231 HEALTH DEPARTMENT—CITY OF BALTIMORE B 9231

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2561 N Baltimore ST.: 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Little

(Residence in Baltimore: No. 2561 N Baltimore St.; 40 yrs., 0 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, September 17, 1877 (Month) (Day) (Year)

7-AGE, 40 yrs. 0 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm E Little

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ellis M. Clos

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Nellie C. Little

(Address) 146 Edmondson Road

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1916, to Oct 13 1917, that I saw him alive on Oct 13 1917, and that death occurred, on the date stated above, at 4 40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. 1 ds.

(Signed) Norman C. Mackenzie M. D.

Oct 14, 1917. (Address) 2219 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER Joseph B. Cook ADDRESS 103 W Saratoga St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 S. Carey St.; 19 WARD) REGISTERED NO. C 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Rubell

(Residence in Baltimore: No. 130 S. Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, DIVORCED (write the word.) Widow

6-DATE OF BIRTH, Oct 15, 1908
(Month) (Day) (Year)

7-AGE, 9 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Rubell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Codd

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Rubell

(Address) 130 S. Carey st

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct, 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Oct 14 1917, that I saw h- alive on Oct 14 1917, and that death occurred, on the date stated above, at 11:05 P m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 3 ds.

(Signed) E. V. Cookelaar M. D.

10/15/17, 191.. (Address) 24 N Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary's Grov	Oct. 15., 191.7.
20-UNDERTAKER John J. Fields	ADDRESS 1200 W. Lombard

4 PM

Spec.—8-24-14—M. & T.—2000 Bks.

D 9233

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 45

D 9233

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Armstrong

(Residence in Baltimore: No. 22 days in Hospital St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widower

6-DATE OF BIRTH, June (Month) 30 (Day), 1843 (Year)

7-AGE, 74 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: R.R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country), N.Y.

PARENTS.

10-NAME OF FATHER, Wm. Armstrong

11-BIRTHPLACE OF FATHER (State or Country), N.Y.

12-MAIDEN NAME OF MOTHER Marion Clark -

13-BIRTHPLACE OF MOTHER (State or Country), N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Phelps

(Address) John Hopkins Hosp.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 191 7, to Oct. 14 191 7, that I saw h[illegible] alive on Oct. 14 191 7, and that death occurred, on the date stated above, at 120 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Prostate

.....

.....

Duration (Duration) .....yrs. 7 mos. .....ds.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) H. P. Batchelor M. D.

Oct. 14, 191 7 (Address) John Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 22 ds. In the State .....yrs. .....mos. 22 ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence Hudson, N.Y.

19-PLACE OF BURIAL OR REMOVAL, Hudson N.Y.

DATE OF BURIAL, Oct. 15, 191 7

20-UNDERTAKER Albert E Fuller

ADDRESS 221 N Broadway

D 9231

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

D 9231

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 318 S Washington ST. 2 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannette O'Brien

(Residence in Baltimore: No. Captain St.: 1 yrs. 27 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 17, 1917 (Month) (Day) (Year)

7-AGE: 1 yrs. 27 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

000 000

9-BIRTHPLACE (State or country): Baltimore. Md.

PARENTS

10-NAME OF FATHER: Thos. O'Brien

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Anna. Price.

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos O'Brien

(Address) 318 S. Washington St.

15

Filed ..... 191 .....

REGISTRAR

is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 13- (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13- 191 7. to, Oct 13- 191 7.

that I saw h~~er~~ alive on Oct 13 191 7.

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) 1 yrs. 1/2 mos. ds

Contributory (SECONDARY) General Exhaustion

(Duration) — yrs. 1 mos. ds.

(Signed) Jno A Brennan M. D.

Oct 14, 1917 (Address) 1258 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Oct 15, 1917.

20-UNDERTAKER: W. F. Sadowski. ADDRESS: 405 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

F 9235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

F 9235

45

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 E Preston St ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Dehler

(Residence in Baltimore: No. 2024 E: Preston St St. 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ale

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH, April (Month) 23rd (Day) 1843 (Year)

7-AGE, 73 yrs. 5 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 614

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Lewis Dehler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Dehler

(Address) 2024 E Preston St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6/10/17, 191..., to 10/11/17, 191..., that I saw h... alive on 10/11/17, 191..., and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Emma M. D.

10/13, 191... (Address) 919 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct. 15th 1917

20-UNDERTAKER John Herwig & Co

ADDRESS 2008 Orleans

Spec.—8-24-14—M. & T.—2000 Blks.

D 9236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2867 W. Lanvale. ST.: 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Woodrow Lewellyn Gray.

(Residence in Baltimore: No. 2867 W Lanvale. St.: Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 28, 1917. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 6 mos. 18 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Robert L. Gray.

11-BIRTHPLACE OF FATHER (State or Country), State of Va.

12-MAIDEN NAME OF MOTHER Margaret B. Flint

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Gray.....

(Address) 2867 W. Lanvale.....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6th 1917, to Oct 14 1917, that I saw him alive on Oct 14th 1917, and that death occurred, on the date stated above, at 12-6 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Broncho

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. mos. ds.

(Signed) Amelia V. Zimmerman M. D.

Oct. 15, 1917. (Address) 1805 W North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park.	Oct. 15, 1917.
20-UNDERTAKER Hue Leach.	ADDRESS 702 E. Monument

Spec.—5-19-13—M. & T.—500 Bks.

D 9237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9237

CERTIFICATE OF DEATH.

6 113

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1526 E Fayette St ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Delahay

(Residence in Baltimore: No. 1526 E. Fayette St

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH ..... November 28 ....., 1871
(Month) (Day) (Year)

7-AGE, ... 45 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Lumber & Cement

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, John Delahay

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Annie Roberts .....

(Address) 1526 E. Fayette St. .....

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 6 1915, to Oct 12 1917, that I saw h[illegible] alive on Oct 12 1917, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

2

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard L. Carlin M. D.

Oct 13, 1917 (Address) 1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, Oct. 16, 1917

20-UNDERTAKER John W Henderson — ADDRESS 31 N Caroline

D 9233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 D 9233

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 42 W.West St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maude Johnson.(C)

(Residence in Baltimore: No. 42 W.West St. St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH. Do not know., (Month) (Day) 1 (Year)

7-AGE, 22 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Johnson.(C) husband.

(Address) 42 W. West St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct. 15. 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct 15 1917

20-UNDERTAKER Samuel I Hendry ADDRESS 578 N Eddle

11 9289 17 70

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9289

CERTIFICATE OF DEATH.

REGISTERED No. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1129 Hartman ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Caspari

(Residence in Baltimore: No. 1129 Hartman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 31, 1850
(Month) (Day) (Year)

7-AGE, 66 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Retail 26

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Caspari

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Bergmann Tuerk

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Son

(Address) 1129 Hartman ave

15-

Filed....., 191.....

C. S. O. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy 1 hour
Arteriosclerosis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None known
(Duration) yrs. mos. ds.

(Signed) C. Mollohan M. D.
(Coroner.)
Oct 16, 191 (Address) 1211 W. Lafayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 15, 1917

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

Important. See instructions on back.

Spec.—5-19-13—M. & T.—500 Blks.

D 9240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9240

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Brantley av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Black

(Residence in Baltimore: No. 1009 Brantley av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of Industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Beard

11-BIRTHPLACE OF FATHER (State or Country), A.A. Co. Md

12-MAIDEN NAME OF MOTHER Harriet Ann Stuart

13-BIRTHPLACE OF MOTHER (State or Country), A.A. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. S. Black

(Address) 2129 Chelsea Ave

15-

Filed ....., 191.....

OCT 15 1917 HARRY C. ANDREWS Registrar. Burial Permit Issued

C. S. S.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12th 1917, to Oct 13 1917, that I saw her alive on Oct 13 1917, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Debility of age

(Duration) — yrs. — mos. — ds.

(Signed) Marshall F Smith M. D.

Oct 13 1917 (Address) 118 N Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 16 1917

20-UNDERTAKER John O. Mitchell — ADDRESS 120 N. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 9241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 9241

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Curley ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Charles Haeffner.

(Residence in Baltimore: No. 819 N. Curley St. St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, August 28, 1916.
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Charles Dennis Haeffner.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City.

12-MAIDEN NAME OF MOTHER Loretta Auld.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Dennis Haeffner

(Address) 819 N. Curley St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1917, to Oct 14 1917, that I saw h.. alive on Oct 14 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

.....2.....

..... Marasmus.....

..... Bronchitis.....

..... (Duration) 2 wks. yrs. mos. ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) (W. P. McCulloch M. D.

Oct 14, 1917. (Address) 2927 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cem.	October 15th, 1917.
20-UNDERTAKER	ADDRESS
Lilly & Ziska	1063 W. Mulberry St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9242 120 D 9242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 So Furrow St.; 20 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Strzelecki

(Residence in Baltimore: No. 306 So Furrow St.; 56 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dec (Month) 26 (Day), 1847 (Year)

7-AGE, 69 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Florist (b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country). Dont Know

12-MAIDEN NAME OF MOTHER Steiger

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John V. Strzelecki

(Address) 306 So Furrow St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1917, to Oct 12 1917, that I saw him alive on Oct 12 1917, and that death occurred, on the date stated above, at 4.15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis 2

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

Oedema (Duration) yrs. 3 mos. 3 ds.

(Signed) Dr. Theo Kalemis M. D.

Oct 13, 1917 (Address) 34 So Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem | DATE OF BURIAL, Oct 16....., 191.

20-UNDERTAKER Stephen Falkowski | ADDRESS 34 So Fulton Ave

Oct

Spec.—8-24-14—M. & T.—2000 Bks.

D 9243 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9243

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 429 W. Hamilt. St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Jones

(Residence in Baltimore: No. 429 W. Hamilt St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... October ....., 1 ..... (Month) (Day) (Year)

7-AGE. ..... yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION. (a) Trade, profession, or particular kind of work ..... (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country) Md

PARENTS.

10-NAME OF FATHER. John Jones

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Martha James

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Jones

(Address) 429 W. Hamilton St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 13 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) Heart Failure

..... (Duration) ..... yrs. ..... mos. 13 ds.

(Signed) [signature] M. D.

Oct 13, 191.7 (Address) 1[illegible] S Stan[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Ct — DATE OF BURIAL. Oct 15, 191.7

20-UNDERTAKER J. L. Brannon's Son — ADDRESS 1[illegible] W Monday

Spec.—8-24-14—M. & T.—2000 Bks.

D 9211 D 9211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 8 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Schwenk

(Residence in Baltimore: No. 1511 E. Lanvale St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 22, 1917 (Month) (Day) (Year)

7-AGE, — yrs. — mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), md.

PARENTS.

10-NAME OF FATHER, Geo. Schwenk

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Ella —

13-BIRTHPLACE OF MOTHER (State or Country). md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Phelps.

(Address) Johns Hopkins Hosp.

15-

Filed....., 191.....

OCT 15 1917 ROBERT P. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1917. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1917, to Oct. 14 1917, that I saw h[illegible] alive on Oct. 14 1917, and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

gastro intestinal intoxication (acute)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Margaret Tyler M. D.

Oct. 14, 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1511 E. Lanvale St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct 16, 191.7

20-UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9245

CERTIFICATE OF DEATH.

120 D 9245

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3835 Roland Ave. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Schutz

(Residence in Baltimore: No. 3835 Roland Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 9th. (Day) 1840 (Year)

7-AGE, 77 yrs. 3 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinest
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Balto. Co.

PARENTS.

10-NAME OF FATHER, John J. Schutz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Needhart

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret A. Schutz

(Address) 3835 Roland Ave.

15-

Filed ....., 191.. .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Oct 13 1917, that I saw h[illegible] alive on Oct 12 1917, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Contracted Kidneys

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Harry E. Agg M. D.

Oct 14, 191.. (Address) 3646 Elm Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetry	Oct. 16, 1917

20-UNDERTAKER	ADDRESS
A.S.Marshall	3539 Falls Road

L.B.P.

D 9216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9216

157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 607 E. Chase 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Neuse

(Residence in Baltimore: No. 607 E Chas St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE 48 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Louisiana

PARENTS.

10-NAME OF FATHER, Newton Chynes

11-BIRTHPLACE OF FATHER (State or Country), Louisiana

12-MAIDEN NAME OF MOTHER Sarah Chynes

13-BIRTHPLACE OF MOTHER (State or Country), Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Neuse

(Address) 607 E. Chase

15-

Filed ....., 191.....
Registrar.

OCT 15 1917 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Laudanum while
probably insane temporary Inebriate
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Epilepsy
(Duration) ....yrs....mos....ds.

(Signed) A. J. Ruby M. D.
(Coroner.)
Oct 15, 1917. (Address) 1659 Dru

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount (Cem) DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER H. C. Kindelon & Son ADDRESS Greenmount

Spec.—8-24-14—M. & T.—2000 Bks.

D 9217 D 9217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Harford Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Maria Horn

(Residence in Baltimore: No. 2232 Harford Ave St.; 66 yrs., 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	married

6-DATE OF BIRTH, November (Month) 25 (Day), 1850 (Year)

7-AGE, 66 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Kalb

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eichhorn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Horn

(Address) 2232 Harford Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1917, to October 13 1917, that I saw h er alive on October 13 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Metastasis in the liver

(Duration) yrs. 2 mos. ds.

(Signed) C. H. A. Harper M. D.

Oct. 14, 1917. (Address) 2436 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Oct. 17, 1917

20-UNDERTAKER George J. Roth

ADDRESS 1735 Harford Ave

D 9248 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9248

169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Body found at foot of Haines St. REGISTERED No. C

CITY OF BALTIMORE (No. ... St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Jefferson.(C)

(Residence in Baltimore: No. 1440 N.Parrish St. St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, September 14th. 1862. , / (Month) (Day) (Year)

7-AGE, 55. yrs. - mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country) Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Dorsey (C) daughter.

(Address) 1740 N. Dallas St.

15-

Filed ....., 191.....

Registrar.

OCT 15 1917 ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Body found October 12th. 1917. 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Death.

Drowning

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Bernhardt M. D. (Coroner)

Oct. 14, 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Oct. 18, 1917
20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9243 — 152 — D 9243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cooke.

(Residence in Baltimore: No. 923 Hollins St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
F.	W.	S.

6-DATE OF BIRTH, 10 (Month) 13 (Day), 1917 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm E Poole

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Pauline Palmer

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

OCT 15 1917 — ROBERT R. FRADTER — JOHNS HOPKINS HOSPITAL — OCT 15 1917

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 13 1917, that I saw her alive on Oct 13 1917, and that death occurred, on the date stated above, at 10 4 m.

The CAUSE OF DEATH* was as follows:

Pyemia Purulent Navel Bilk

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Ernest P. McKay M. D.

Oct 13, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. 1 ds.

Where was disease contracted, if not at place of death? Johns Hopkins Hosp.

Former or usual residence Johns Hopkins Hospital

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL.	OCT 15 1917 ....., 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

Per. Wm E. WOODALL

22

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9250 D 9250

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 N. Parrish ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Howard

(Residence in Baltimore: No. 827 N. Parrish St.; 62 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) widow

6-DATE OF BIRTH, Apr. 14, 1855. (Month) (Day) (Year)

7-AGE, 64 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic 070
(b) General nature of industry, business, or establishment in which employed (or employer): Private families

9-BIRTHPLACE, (State or Country), Frederick Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hiriet R. Howard

(Address) 827 N. Parrish St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2- 1917, to Oct. 13 1917, that I saw h[illegible] alive on Oct. 11- 1917, and that death occurred, on the date stated above, at 9 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. McLenfest M. D.

Oct. 13., 1917. (Address) 906 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Oct. 16 1917

20-UNDERTAKER Sam. McChane-son — ADDRESS 1400 Monroe St

Spec.—5-19-13—M. & T.—500 Blks.

D 9251

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9251

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Furrow St. St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Becker

(Residence in Baltimore: No. 413 Furrow St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 29, 1874
(Month) (Day) (Year)

7-AGE, 43 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... B & O R.R. Co.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Becker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Becker

(Address) 415 Furrow St.

15-

OCT 15 1917

ROBERT H. KRAUTER
Registrar of Vital Statistics, Clerk

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1915, to Oct 12 1917, that I saw h— alive on Oct 12 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. W. Phillips M. D.

....., 191... (Address) 1701 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 16, 1917.

20-UNDERTAKER F. B. Hesselbrock ADDRESS 2136 Frederick Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

9252 9252

CERTIFICATE OF DEATH.

17

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Helen Elaturin Yard St. 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Trunick

(Residence in Baltimore: No. 2731 Greenmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 20, 1862
(Month) (Day) (Year)

7-AGE, 55 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Train Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 073

9-BIRTHPLACE, (State or Country), Montgomery Co. Md.

PARENTS.

10-NAME OF FATHER, James Trunick

11-BIRTHPLACE OF FATHER (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER Ann Clement

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catharine Trunick

(Address) 2731 Greenmount

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck & Killed - & Left Mashed
Struck by Cars. at Fulton Ave
(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Accidental
(Duration) yrs. mos. ds.

(Signed) W T Riley M. D.
(Coroner.)
....., 191.7 (Address) 1637 Sunday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Marys Cem. Govans. DATE OF BURIAL, 10/16, 1917

20-UNDERTAKER Henry W. Meas & Son ADDRESS 525 N. Gaston Ave

Minnie M. Kaiser

9253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St.; WARD)

REGISTERED No. C 9253

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie M Kaiser

(Residence in Baltimore: No. 637 E S E Washington Pl St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 3 (Day) 85 (Year)

7-AGE, 32 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, James Lamar

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sara May,

13-BIRTHPLACE OF MOTHER (State or Country) Novo Scotia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas A Kaiser

(Address) 623 E St Washington

15-

Filed....., 191.....

ROBERT P. KRAUTER
Registrar.

Important. See instructions on back of this sheet.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism in Cerebral Arteriosclerosis

months (Duration) hour yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Wm Chesney M. D.
(Coroner.)

, 191... (Address) 911 E Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. 2 mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Washington Bd.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington D C — DATE OF BURIAL, Oct 15, 1917

20-UNDERTAKER Geo. A. Gerbig — ADDRESS Baltimore Md

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 0251 40 D 0251

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Marion Brown

(Residence in Baltimore: No. ~~Westminster~~ Apt. 4 Hospital St.; yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 10 (Day), 1866 (Year)

7-AGE, 51 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, Jermiah Methias

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md.

12-MAIDEN NAME OF MOTHER Mary Methias

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Brown

(Address) Westminster Md.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1917, to Oct. 16 1917, that I saw her alive on October 16 1917, and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) General Carcinoma

Duration) ....yrs. ....mos. ....ds.

(Signed) W. W. Chew M. D.

Oct. 16., 1917. (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State 51 yrs. 4 mos. 6 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Westminster Md.

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, Oct. 16 1917.

20-UNDERTAKER J. H. Bankard & Son

ADDRESS Westminster Md

Spec.--5-19-13--M. & T.--500 Blks.

D 9255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9255

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1207 Park ave.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Taylor

(Residence in Baltimore: No. 1207 Park ave.; 25 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX fem.

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Oct. ~~12~~, 1880
(Month) (Day) (Year)

7-AGE, 37 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... employee in hospital
(b) General nature of industry, business, or establishment in which employed (or employer) ... in hospital 070

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Taylor

(Address) 569 Orchard St

15-

Filed ... 191 ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~on~~ Oct. 13 1917, to ... 191 ..., that I saw her alive on Oct. 13 1917, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. L. Lummis M. D.

Oct. 14, 1917. (Address) 2226 Madison ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lamont Cemetery

DATE OF BURIAL, Oct. 16, 191.

20-UNDERTAKER John A. Bishop

ADDRESS 110 S Hilton

D 9256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9256

175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Post Hospital ST.: WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Heywood.

(Residence in Baltimore: No. 418 E Lafayette Ave St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, Aug. (Month) 2 (Day), 1906 (Year)

7-AGE, 11 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) Girl

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frank Heywood

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Bell-white

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Heywood

(Address) 418 E. Lafayette

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Meningitis

Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct. 16, 1917. (Address) 418 E. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Lafayette

Former or usual residence 418 E Lafayette Ave

19-PLACE OF BURIAL OR REMOVAL, Loraine Cem. DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER W. M. Sawtell ADDRESS 1624 Mt Royal ave

Important. See instructions on back of certificate.

Spec.—5-19-13 M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 N. Chester ST.; 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Columbus Henry Hahn

(Residence in Baltimore: No. 2021 Orleans St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 5, 1887
(Month) (Day) (Year)

7-AGE. 29 yrs. 10 mos. 9 ds.

If LESS than 1 day. hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Letter Carrier
(b) General nature of industry, business, or establishment in which employed (or employer). U.S. Postal Service

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Geo. W. Hahn

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Alice Mathais

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Hahn

(Address) 2238 N. Chester

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Oct 14 1917, that I saw h m alive on Oct 14 1917, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion following Stomach Trouble

(Duration) 1 yrs. mos. ds.

(Signed) Edward J. Coulson M. D.

10/15, 1917. (Address) 1137 N. Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Oct 17, 1917.

20-UNDERTAKER Chas. G. Black

ADDRESS 1201 W. Mulberry St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9253 92 D 9253

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 W. Lafayette ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola E Fisher

(Residence in Baltimore: No. 54 W Lafayette ave St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 18, 1895 (Month) (Day) (Year)

7-AGE, 22 yrs. 3 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) 068

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joshua Fisher

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Maggie E Baker

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie E Fisher

(Address) 157 W Lafayette ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Oct 14 1917, that I saw he.. alive on Oct 14 1917, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

2 (Duration) yrs. mos. 7 ds.

(Signed) Edward Schatt M. D.

Oct 14, 1917 (Address) 1812 Druid Hill ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W.A. Auburn Cemetery

DATE OF BURIAL, Oct 17, 1917

20-UNDERTAKER John H Tondrin

ADDRESS 1430 Pierce St

47

D 9259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9259

CERTIFICATE OF DEATH.

19

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 649 N. Paca ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William H. Burgess

(Residence in Baltimore: No. 649 N Paca St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 28 (Day), 1894 (Year)

7-AGE, 23 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter 086
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Burgess

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 649 N. Paca St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1913
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Hypertrophy of Heart & Dilatation of Heart & Failure of Valves of the Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hard work

(Duration) yrs. mos. ds.

(Signed) H. Nicholson M. D.
(Coroner.)

Oct 13, 1913. (Address) 809 N Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 23 yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct 16, 1913

20-UNDERTAKER John H. Todd Inc

ADDRESS 1420 Hillen

D 9260

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1550

D 9260

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 812 W Barre St. 21 WARD)

Registered No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Burton

(Residence in Baltimore: No. 812 Barre St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): single

6-DATE OF BIRTH: Oct 14 (Month) (Day), 1917 (Year)

7-AGE: ..... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Clarence Burton

11-BIRTHPLACE OF FATHER (State or country): Ella Baltimore

12-MAIDEN NAME OF MOTHER: Ella Smith

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Burton

(Address) 812 W Barre St

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 15 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1917, to Oct 15 1917

that I saw h~ alive on Oct 14, 1917.

and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Failure of Formen Oval to Close

..... (Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY): None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rykard Davis M. D.

Oct 15, 191 (Address) (22) Glenwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western

DATE OF BURIAL: Oct 16th, 1917.

20-UNDERTAKER: John J Fields

ADDRESS: 1200 W Lombard

is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9261 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9261

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1427 S Charles ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Isaac

(Residence in Baltimore: No. 1427 S Charles St. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widr.

6-DATE OF BIRTH, Oct 6 (Month) (Day), 1840 (Year)

7-AGE, 77 yrs. — mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 615

9-BIRTHPLACE, (State or Country), Elliot City H. Co.

PARENTS.

10-NAME OF FATHER, George A. Isaac

11-BIRTHPLACE OF FATHER (State or Country), Elliot City H Co

12-MAIDEN NAME OF MOTHER, Nancie Ward.

13-BIRTHPLACE OF MOTHER (State or Country), Elliot City Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mine Bazaar

(Address) 1427 S Charles St

15-

Filed.....; 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 1917, to Oct 13 1917, that I saw h[im] alive on Oct 13 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) Geo L. Shane M. D.

Oct 13, 1917 (Address) 711 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park East	Oct 16, 1917.
20-UNDERTAKER Wm. J. Brandt	ADDRESS 1420 W Pratt St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9262

CERTIFICATE OF DEATH.

40

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Foster Ave St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mehring

(Residence in Baltimore: No. 2437 Foster Ave St.; 45 yrs., 9 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 24, 1871 (Month) (Day) (Year)

7-AGE, 45 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), ~~Germany~~ City

PARENTS.

10-NAME OF FATHER, Matthias Mehring

11-BIRTHPLACE OF FATHER (State or Country), Bavaria

12-MAIDEN NAME OF MOTHER Barbara Stickline

13-BIRTHPLACE OF MOTHER (State or Country), Bavaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bertha Mehring

(Address) 2437 Foster Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 29 1917, to October 15 1917, that I saw him alive on Oct 14 1917, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Chronic (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alfred A. Brandeth M. D.

Oct. 16, 191.. (Address) 5 S. Patterson Pk.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Oct 18, 1917.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2048 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9263

CERTIFICATE OF DEATH.

8 28 D 9263

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 E Chase St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Markland

(Residence in Baltimore: No. 2406 E Chase St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 25 (Month) (Day), 1893 (Year)

7-AGE, 24 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary A. Hoffman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. Markland

(Address) 2406 E. Chase St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 2 mos 3 d 1917, to Oct 13 1917,

that I saw h.. alive on Oct 13 1917,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

..... Duration

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Rehn M. D.

Oct 16, 191.. (Address) 1639 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Oct 16 191 7

20-UNDERTAKER Robt. J. Turnbull

ADDRESS 3344 Brookline

Spec.—8-24-14—M. & T.—2000 Bks.

D 9261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9261

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1001 N. Bruce ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sydney A. Powell

(Residence in Baltimore: No. 1001 N. Bruce St.; 2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, January (Month) 13 (Day), 1899 (Year)

7-AGE, 18 yrs. 9 mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, A. Hankerson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William D. Powell

(Address) 1001 N. Bruce St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 11 1917, to October 14 1917, that I saw h.. alive on October 14 1917, and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D. Summerell. D.

Oct. 14 1917. (Address) 1502 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Aberdun Station	Oct 17, 1917

20-UNDERTAKER	ADDRESS
Aberdun Md Edward Ringgold	1763 N. Bruce St

D 9265

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9265

1 PLACE OF DEATH — REGISTERED No. C 120

CITY OF BALTIMORE (No. 1420 S Charles St.: 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Meyer

(Residence in Baltimore: No. 1420 S. Charles St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: 12 (Month) – 20 (Day), 1843 (Year)

7 AGE: 74 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 000

9 BIRTHPLACE (State or country): Switzerland

PARENTS

10 NAME OF FATHER: do not Know

11 BIRTHPLACE OF FATHER (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: do not Know

13 BIRTHPLACE OF MOTHER (State or country): Switzerland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Meyer

(Address) 1420 S Charles

15.

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 14 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1917, to Oct 14 1917, that I saw h[illegible] alive on Oct 14 1917, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Anemia

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

(Signed) C Mitchell M. D.

Oct 16, 1917 (Address) 1279 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cem — DATE OF BURIAL: Oct 17, 1917

20 UNDERTAKER: John F Fahey & Son — ADDRESS: 1318 Light St

OCT 16 1917 MARY C. AS REWE Burial Permit Clerk

is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9263

HEALTH DEPARTMENT—CITY OF BALTIMORE

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D 9266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 1 WARD) REGISTERED No. C

2-FULL NAME Mary Hoey

(Residence in Baltimore: No. 7211 Gough St. St.; Life yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. (Month) 2 (Day), 1843 (Year)

7-AGE, 74 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles F. Stagemeyer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dora Schaffer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10 1917, to Oct. 13 1917, that I saw h[er] alive on Oct. 12 1917, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Accident Traumatism

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Injuries of Shock

(Duration) yrs. mos. ds.

(Signed) Edward F. Smith M. D.

Oct. 13 191 7. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? 7211 Gough St

Former or usual residence 7211 Gough St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Oct. 17th, 191
20-UNDERTAKER	ADDRESS
Lilly & Fike	403 N. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9267 D 9267

CERTIFICATE OF DEATH.

X 138

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. University Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Bennett

(Residence in Baltimore: No. 35 36 Wayside Place St.; ... yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1894.
(Month) (Day) (Year)

7-AGE, 23 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waitress
(b) General nature of industry, business, or establishment in which employed (or employer): at Eagle

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. Bennett

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ida Hunter

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. C. Mariner

(Address) University Hospital

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11 1917, to Oct. 13 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

... Cardiac Dilatation

... (Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia Croupous

... (Duration) ... yrs. ... mos. 3 ds.

(Signed) Frank C. Mariner M. D.

Oct. 13, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State 23 yrs. ... mos. 2 ds.

Where was disease contracted, if not at place of death? 2

Former or usual residence 35 36 Wayside Place.

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cem.

DATE OF BURIAL, Oct. 16, 1917.

20-UNDERTAKER Lilly & Gaile

ADDRESS 403 N. Mo[illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D 9268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9268

1-PLACE OF DEATH U. S. Marine Hospital 28

CITY OF BALTIMORE: (No. U. S. Marine Hospital St.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chris. Burrell

(Residence in Baltimore: No. U. S. Marine Hospital St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Unknown, 1 (Month) (Day) (Year)

7-AGE. 39 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fireman
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) ...

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1917 to October 15 1917, that I saw him alive on October 15 1917, and that death occurred, on the date stated above, at 3.48 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic

Pulmonary

(Duration) ... yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. H. Vogel M. D.

Oct 16, 1917 (Address) U. S. Marine Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 5 mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. Oct. 17, 1917.

20-UNDERTAKER Lanahan & Son ADDRESS 617 Eastern Ave.

D 9269

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9269

40

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2307 Orem Ave. St.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie A. Hobbs.

(Residence in Baltimore: No. 2307 OREM Ave. St.: 20 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female.	white.	widow.

6 DATE OF BIRTH June 28, 1852. (Month) (Day), 1852 (Year)

7 AGE 65 yrs. 3 mos. 19 ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work retired home.
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) Maryland.

PARENTS

10 NAME OF FATHER John D Alcock.

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER M. Ridgely.

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgr Craig (daughter)

(Address) 2307 Orem Ave.

15.

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 15, 1917.
(Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 20, 1917 to October 15, 1917.

that I saw her alive on October 15, 1917.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (cancer) of the Bladder. Clinical

2 months. — — —
(Duration) yrs. mos. ds

Contributory (SECONDARY) none.

(Duration) yrs. mos. ds.

(Signed) David I. Macht. M. D.

Oct. 16, 1917 (Address) 3218 Rochester & Towsn.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Howard Co. Md.	Oct 17th, 1917
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Baltimore St.

OCT 16 1917 HARRY C. ANDREWS Asst. Registrar

Note—This certificate is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 9270 64 B 9270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N. Monroe ST.: 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Isabelle Meyers

(Residence in Baltimore: No. 1124 N. Monroe St St.; 57 yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 10, 1860 (Month) (Day) (Year)

7-AGE, 57 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John L. Luther

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Rose A Hanna

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Myers

(Address) 1124 N Monroe

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 14 1917, to Oct 15 1917, that I saw h er alive on Oct 15 1917, and that death occurred, on the date stated above, at 6.10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 0 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. 6 mos. ds.

(Signed) W. L. Rolfes M. D.

10/15, 1917. (Address) 814 N. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 17, 191..

20-UNDERTAKER J. D. Cook

ADDRESS 1003 W Balto St

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9271

CERTIFICATE OF DEATH.

104 D 9271

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 N. Appleton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris G. Frazier

(Residence in Baltimore: No. 1021 N. Appleton St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 1 (Day), 1917 (Year)

7-AGE, ...yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Clarence R. Frazier

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Amelia M. Walters

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Walters

(Address) 1021 N. Appleton St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Oct 14 1917, that I saw h.im alive on Oct 13 1917, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Chas. G. Consen M. D.

Oct 15, 1917. (Address) 1107 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 16 m, 1917.

20-UNDERTAKER M. Fahey & Sons

ADDRESS 16 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9272

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806. S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena Ostrowska

(Residence in Baltimore: No. 806 S. Bond St ST.; 1 yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 4, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ignatius Ostrowski

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Tekla Borey

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ignatius Ostrowski

(Address) 806 S. Bond St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 4 1917, to Oct 15 1917, that I saw h[er] alive on Oct 12 1917, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Gen. Tuberc.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 10 ds.

(Signed) A. T. Ras M. D.

Oct 16, 1917. (Address) 24 S. Bdwy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct 16, 1917

20-UNDERTAKER William Fiaskowski

ADDRESS 618 Eastern Ave.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9273 91 D 9273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 W. Fayette ST.; 18 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Pettet

(Residence in Baltimore: No. 811 W Fayette St St.; yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Widower

6-DATE OF BIRTH: Jan (Month) (Day), 1828 (Year)

7-AGE: 89 yrs. 10 mos. — ds. If LESS than 1 day, hrs. or min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Mt Known

11-BIRTHPLACE OF FATHER (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mt Known

13-BIRTHPLACE OF MOTHER (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M E Morgan

(Address) Washington Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 15, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Oct 15 1917, that I saw h alive on Oct 14 1917, and that death occurred, on the date stated above, at 7.30 Pm.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Exhaustion

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senile pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) J. T. Pettet M. D.

10.16., 1917. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Fair Hap Va.

DATE OF BURIAL: Oct 16, 1917.

20-UNDERTAKER: W M Routson

ADDRESS: 230 N Green

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9274 — 28 — D 9274

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Bowling

(Residence in Baltimore: No. 2911 Dillon St.; 68 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 30, 1849 (Month) (Day) (Year)

7-AGE, 68 yrs. 4 mos. 13 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired Rigger
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Thomas Bowling

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Susanna Broome

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Bowling

(Address) 2911 Dillon St.

15-

OCT 16 1917 ROBERT B. BEAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Oct 14 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. McAvoy M. D.

Oct 15, 1917. (Address) 839 S. Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Oct 17, 1917.

20-UNDERTAKER John A. Inman

ADDRESS 3000 E Baltimore St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9275

CERTIFICATE OF DEATH.

50 D 9275

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 W. Lexington St. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos F. Warner

(Residence in Baltimore: No. 1937 W Lexington St St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Widowed

6-DATE OF BIRTH. August 27th 1861.
(Month) (Day) (Year)

7-AGE. 56 yrs. 1 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer): Calvert Distg Co

9-BIRTHPLACE. (State or Country). Springfield Ohio

PARENTS.

10-NAME OF FATHER. John Warner

11-BIRTHPLACE OF FATHER (State or Country). Springfield Ohio

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Springfield Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. D. McLee

(Address) 1937 W Lexington

15-

Filed ....., 191.....

Registrar.

OCT 16 1917 ROBERT B. CRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1917, to Oct 15th 1917, that I saw h.. alive on Oct 14th 1917, and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

a. Coronary Thrombosis

b.

c.

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) yrs. 6 mos. ds.

(Signed) Benj. O'Connor M. D.

Oct 15, 1917. (Address) 400 N. Payson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Oct 17th, 1917

20-UNDERTAKER John J. Cowan & Son ADDRESS 901 W. Pratt St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9276

CERTIFICATE OF DEATH.

REGISTERED NO. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 E. Lombard ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Holmes

(Residence in Baltimore: No. 2209 E. Lombard st, St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, March (Month) 22 (Day), 1892 (Year)

7-AGE, 25 yrs. 6 mos. 24 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Servant
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida Roberts

(Address) 2209 E. Lombard st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 191 7, to Oct 15 191 7, that I saw h[illegible] alive on Oct 15 191 7, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yr. mos. ds.

(Signed) J. T. Bucknall M. D.

Oct 16, 191 7. (Address) 2112 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Port Valley Georgia

DATE OF BURIAL, Oct. 16, 1917.

20-UNDERTAKER Wm C. Black

ADDRESS 1. Broadway

OCT 16 1917 ROBERT B. KRAUTH REGISTRAR OF VITAL STATISTICS

9227

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Goldman

(Residence in Baltimore: No. Camp. Mead. Md St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Single.

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
27 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cloak Maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 080

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Goldman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Wapnick

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Goldman

718 Bambridge Phil.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ..death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, and internal injuries caused by being hit by Pennsylvania R.R. train at Camp Mead.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. S. Driscoll M. D. (Coroner.)

Oct 16, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. ..... ds. In the State ..... yrs. 1 mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Philadelphia

E OF DEATH in plain terms, as this may be property evidence. Case number to correspond with that on certificate. See instructions on back of certificate. 48

CAUSE OF DEATH in plain terms. Omit terms not important. See instructions on back.

PARENTS.

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Wapnick

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Goldman

(Address) 718 Bambridge Phil.

15-

Filed ....., 191...

Registrar.

(Signed) ..... M. D.

Oct 16, 191 7 (Coroner.) (Address) 512 N Carrollton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. ....ds. In the State ....yrs. 1 mos. ....ds.

Where was disease contracted, if not at place of death? .....

Philadelphia

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa — DATE OF BURIAL, Oct 16, 191 7

20-UNDERTAKER S. Spinner & Bro — ADDRESS 1107 E Balto St

Spec.—8-24-14—M. & T.—2000 lks.

D 9278

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

113

D 9278

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 503 S Belnord ave St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Seidl.

(Residence in Baltimore: No. 503 S. Belnord ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Oct. 27, (Month) (Day) 1873 (Year)

7-AGE, 44 yrs. 11 mos. 16 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife.
X (b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Dell

11-BIRTHPLACE OF FATHER (State or Country), U. S.

12-MAIDEN NAME OF MOTHER Kate Sommers

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. L. Seidl

(Address) 503 S. Belnord ave.

15-

OCT 16 1917 ROBERT R. KRAUTER

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 15 (Day), 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 15 191 7, to Oct 11 191 7, that I saw her alive on Oct 5 191 7, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

..... (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 16 191 7 (Address) 1107 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct. 18, 191 7.

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 S Wolfe

Spec.—8-24-14—M. & T.—2000 Bks.

D 9279

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9279

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2025 Mc Elderry St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary K. Kirchner.

(Residence in Baltimore: No. 2025 Mc Elderry. St.; 33 yrs., 7 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. 27th, 1884
(Month) (Day) (Year)

7-AGE. 33 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sabastian L. Schnader

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Raub.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis E. Kirchner

(Address) 2025 Mc Elderry St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1917, to Oct 13 1917, that I saw her alive on October 13 1917, and that death occurred, on the date stated above, at 1 15 A, m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(b)

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Glendinning M. D.

Oct. 15, 1917 (Address) 102 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct. 17, 1917

20-UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9280

CERTIFICATE OF DEATH.

19 D 9280

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115. Callow, ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary D. Waumnertach

(Residence in Baltimore: No. 2115. Callow ave St.: 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept 26th, 1834 (Month) (Day) (Year)

7-AGE, 83 yrs. 0 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or estsblishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wm Pleker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wilhelmina Krupp

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aug. F. Klauer

(Address) 211 S. Callow ave

15-

OCT 16 1917 ROBERT B. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-30 pm Oct 15 1917, to 7-30 pm Oct 15 1917, that I saw h[illegible] alive on Oct 15th 1917, and that death occurred, on the date stated above, at 7-30 p.m.

The CAUSE OF DEATH* was as follows:

Oedema of the lungs

One hour

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Mitral Heart Leak

(Duration) 10 yrs. mos. ds.

(Signed) Eugene Douglass M. D.

Oct 17th, 1917. (Address) 829 W. Fredrick

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Oct 18, 1917
20-UNDERTAKER Graham & Weber	ADDRESS 723 W Lex Ave

Eugene Douglass 7 week W2

Spec.—8-24-14—M. & T.—2000 Bks.

D 9281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D 9281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Abbott ST. 7 WARD) REGISTERED No. C

2-FULL NAME Rosie Martinek

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1612 Abbott St.; 40 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Not Known (Month) (Day), 1 (Year)

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Fallat

(Address) 1612 Abbott St

15-

Filed....., 191.....

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 14 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas B. Kegler M. D.

Oct 13, 1917. (Address) 833 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Oct 17, 1917
20-UNDERTAKER Frank Cracknell Son	ADDRESS 1416 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9282 D 9282 98

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 509 N Port ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Sappington

(Residence in Baltimore: No. 509 N Port St St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, September 26, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. - mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Greenbury Sappington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary E Slatting

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie May Sappington

(Address) 509 N. Port St

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 191.., to Oct 14 1917, that I saw h[illegible] alive on Oct 12 191.., and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) F. S. Keyser Jr M. D.

Oct 15, 191.7 (Address) 604 S Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Friendship Cemetary A & Co — DATE OF BURIAL, Oct 17 17., 191...

20-UNDERTAKER Christian Miller — ADDRESS 233 Jefferson st

Spec.—8-24-14—M. & T.—2000 Bks.

D 9283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9283

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1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N. Central ave ST.: 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 433 N. Central ave St.: yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown (Month), (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic 070
(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Brantley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Jenkins

(Address) 433 N. Central ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 14 (Day), 1917. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1917, to Oct 13, 1917, that I saw h r alive on Oct 13, 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert L. Green M. D.

Oct 15, 1917. (Address) 120½ Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Asbury

DATE OF BURIAL. Oct. 17., 1917.

20-UNDERTAKER John W. Henderson

ADDRESS 31 N Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9281 — 76 ✓ — D 9281

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 E Fayette St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Larkins

(Residence in Baltimore: No. 1528 E Fayette St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, ...yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Roger Larkins

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Elizabeth Braxton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Larkins

(Address) 1528 E Fayette St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 to ..... 191 ,

that I saw him alive on Oct. 2, 1917 ,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Otitis Media Acute over

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. Julian Chisolm M. D.

Oct. 15, 191.. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence 1528 E. Fayette St

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Oct 17, 1917

20-UNDERTAKER John A Henderson

ADDRESS 311 N Eutaw

OCT 17 1917 HARRY G. ANDREWS Burial Permit Clerk

Hattie Moseley

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9285 ✓ 91

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 524 N. Spring St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Moseley

(Residence in Baltimore: No. 524 N. Spring St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colord

5-~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7-AGE: 56 yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer): Laundress 844

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H Annie Commisger

(Address) 524 N Spring St

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 15 (Day), 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Sept 5, 191 7, to, Oct 1, 191 7,
that I saw her alive on Sept 13 191 7,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis - pneumonia

(Duration) yrs 1 mos. ds.

Contributory (SECONDARY) Respiratory

~~Fracture~~ (Duration) yrs mos. 1 ds.

(Signed) E. C. Jones M. D.

Oct 16, 191 7 [Address] Church Home

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 17, 191 7

20-UNDERTAKER: Wm Robert H Elliott — ADDRESS: 506 East St

TION is very important. See instructions on

D 9286

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9286

CERTIFICATE OF DEATH.

174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Fennick

(Residence in Baltimore: No. 1536 McElderry. St.: yrs., 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	Widower

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

3

9-BIRTHPLACE, (State or Country), St. Marys Co.

PARENTS.

10-NAME OF FATHER, Ignatius Fennick

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances Morris

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor Fennick

(Address) 1536 McElderry St

15-

Filed....., 191.....

Registrar.

OCT 17 1917 HARRY O. RUSLER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Depression of skull (accidental)

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner)

Oct 16 1917 (Address) 710 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Co Md	Oct 17, 1917
20-UNDERTAKER	ADDRESS
R G Gross	1405 McElderry St

Important. See instructions on back of certificate.

D 9287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 945 Linden Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Faccioli

(Residence in Baltimore: No. 945 Linden Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. (Month) 6 (Day) 1857 (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 9 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 056
(b) General nature of industry, business, or establishment in which employed (or employer): Grocer

463

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, McKeon

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Watson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife

(Address) 945 Linden Ave

15-

Filed....., 191.....

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Compensation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) 4 yrs. mos. ds.

(Signed) J. Whitridge Williams M. D.
(Coroner)

Oct 15 1917 (Address) 8 W. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State 40 yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Oct. 17, 1917

20-UNDERTAKER Stewart & Co

ADDRESS 108 W. Mt. Royal Ave

Important.—See instructions on back of certificate.

OCT 17 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 9283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 9283

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 834 Park Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Sebastian Graff Baker

(Residence in Baltimore: No. 834 Park Ave St.; 80 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. January 6, 1836 (Month) (Day) (Year)

7-AGE. 81 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Manf'r 04

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. not known

11-BIRTHPLACE OF FATHER (State or Country) not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. S. G. Baker

(Address) 760 E. 33rd St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 16, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1st 1917, to October 16 1917, that I saw h= alive on Oct 16 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

(a) Cerebro Sclerosis

(b) Nephritis chronic

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Ritter M. D.

Oct 17, 1917 (Address) 1163 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. ✓ ds. In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence ✓

19-PLACE OF BURIAL OR REMOVAL. Green Mount Cy

DATE OF BURIAL. Oct 17, 191..

20-UNDERTAKER Stuart Mowen Co

ADDRESS 108 N Mott Ave

Spec.—8-24-14—M. & T.—2000 Bks.

0289 0289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 ✓

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 W Franklin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Walker

(Residence in Baltimore: No. 941 W Franklin St.) 40 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, January ? (Month) (Day), 1836 (Year)

7-AGE, 71 yrs. 9 ? mos. ? ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. G. Walker

(Address) 941 W. Franklin St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1917, to Oct. 14 1917, that I saw him alive on Oct. 14 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes & General Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Howard M. D.

Oct. 17, 1917. (Address) 1042 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 2 ds. In the State — yrs. — mos. 1 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER Stewart Mower Co ADDRESS 918 N Howard St

D 9290

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓

D 9290

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1618 Harford ave St. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Louis Eisenhauer

(Residence in Baltimore: No. 1618 Harford ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Nov 15, 1850 (Month) (Day) (Year)

7-AGE: 67 yrs. 11 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer): Coat maker

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Adam Eisenhauer

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine Eisenhauer

(Address) 1618 Harford ave

15

OCT 17 1917 HARRY C. AMBRA

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 15, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1916, to Oct 15 1917. that I saw him alive on Oct 14, 1917. and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

Clinical (Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Frances D McCarran M. D.

Oct 16, 1917. (Address) 4166 North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 18, 1917

20-UNDERTAKER: Frank A. Fink — ADDRESS: 915 N. Gay St

If death occurred in a hospital or institution, or if the body was found elsewhere than at the residence, this portion of certificate is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks. Clara Rentkiewicz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9291 92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 417 Griffin St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Rentkiewicz

(Residence in Baltimore: No. 417 Griffin St. St.; 1 yrs., 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. 7th, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 9 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Rentkiewicz

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland.

12-MAIDEN NAME OF MOTHER Annie Kasprowicz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Rentkiewicz

(Address) 417 Griffin St.

15-

OCT 17 1917

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct-16 1917, that I saw her alive on Oct-16 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos. 2 ds.

(Signed) ..... M. D.

Oct. 16, 1917. (Address) 1.1.8 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary.	Oct 18, 1917.
20-UNDERTAKER	ADDRESS
M. F. Sadowski	705 Lisbon

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9292 — D 9292

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. Milton Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodor Kuzniarski

(Residence in Baltimore: No. 711 S. Milton Ave. St.; 1 yrs., mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 3 (Day) 1916 (Year)

7-AGE, 1 yrs. mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " " 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Martin Kuzniarski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Francis Drankewicz

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Kuzniarski

(Address) 711 S. Milton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 16 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22 1917, to Oct 16 1917, that I saw him alive on Oct 16 1917, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) yrs. 4 mos. 3 ds.

(Signed) Geo. Keller M. D.

Oct. 16, 1917 (Address) 1937 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Oct 17, 1917
20-UNDERTAKER	ADDRESS
William Fialkowski	711 Canton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9293 D 9293

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 N Patterson Park Ave St.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Soltz

(Residence in Baltimore: No. 837 N Patterson Park Ave St.; 58 yrs. 10 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Nov. 22, 1858 (Month) (Day) (Year)

7-AGE, 58 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothing Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 081

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Heinz Soltz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christina Miller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Soltz

(Address) 837 N Patterson Park Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 15 1917, to Oct. 14 1917, that I saw h[illegible] alive on Oct. 14 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) Ernst Krug M. D.

Oct 16, 191.. (Address) 7 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 18, 191.7.

20-UNDERTAKER John Herweg & Co

ADDRESS 200 Orleans St

HEALTH DEPARTMENT–CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9291 ✓ 120

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 612 Baker St.: 15 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME David E Burrow

(Residence in Baltimore: No. 612 Baker St.: 6 yrs. 11 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

6 DATE OF BIRTH Nov 1st, 1910 (Month) (Day) (Year)

7 AGE 6 yrs. 11 mos. 15 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

000

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Burrow

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Hill

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah A. Burrow

(Address) 612 Baker St

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 15, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1917 to Oct 15 1917 that I saw h[illegible] alive on Oct 14, 1917 and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cardio-Renal
Mitral Insufficiency & Chronic Nephritis (Duration) yrs. 8 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) John Eberly M. D.

Oct 15, 191. (Address) 700 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 17th, 1917

20 UNDERTAKER Geo. H. Holland ADDRESS 1631 Monroe Ave

OCT 17 1917

Size CAUSE OF DEATH in plain terms. Do not use abbreviations or physicians' technical expressions. Cause of death is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

D 9295

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Bond ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Davis

(Residence in Baltimore: No. 516 N. Bond St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, C.G.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Carroll

(Address) 516 N. Bond St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 15, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Aug 31 1917, to Oct. 15, 1917, that I saw h last alive on Oct. 14 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Nephritis over

(Duration) ... yrs. 3 mos. ... ds.

(Signed) H. K. Cairns M. D.

10/19 1917 (Address) 152 N. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Zion cemetery

DATE OF BURIAL. Oct 19 1917

20-UNDERTAKER Joseph A. Farrell

ADDRESS 2311 Division St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 0296 — 119 — F 0296

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5032 W. Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Tucker

(Residence in Baltimore: No. 5032 W. Mulberry St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Jan. (Month) 22 (Day), 1874 (Year)

7-AGE: 42 yrs. 8 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tent & Awn
(b) General nature of industry, business, or establishment in which employed (or employer): Maker

9-BIRTHPLACE, (State or Country): Balto. md

PARENTS.

10-NAME OF FATHER: John T Tucker

11-BIRTHPLACE OF FATHER (State or Country): Balto md

12-MAIDEN NAME OF MOTHER: Mary E Watts

13-BIRTHPLACE OF MOTHER (State or Country): Calvert Co md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth T Tucker

(Address) 5032 W. Mulberry St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1917, to Oct 17 1917, that I saw h[illegible] alive on Oct 16 1917, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

TSW

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary) Urinæ Examination

(Duration) ....yrs. ....mos. 1 ds.

(Signed) A. J. McLaughlin M. D.

Oct 17, 1917. (Address) 826 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemt

DATE OF BURIAL: Oct 19, 1917

20-UNDERTAKER: H. M. Cook

ADDRESS: 502 E North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9297 64 D 9297

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3010 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Albert

(Residence in Baltimore: No. 3010 Hudson St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 1 Don't Know, 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben. Albert

(Address) 3010 Hudson St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1917, to Oct 15 1917, that I saw her alive on Oct 12 1917, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos McAvoy M. D.

Oct 15, 1917 (Address) 839 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Schwartz Chr

DATE OF BURIAL, Oct 18, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 S Monta

Spec.—3 24-14—M. & T.—2000 B—

D 9298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D 9298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Hanover ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura A Hardesty

(Residence in Baltimore: No. 615 S. Decker ave. St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... Feb. (Month) 9 (Day), 1849 (Year)

7-AGE, 68 yrs. 8 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Richard Harwood.

11-BIRTHPLACE OF FATHER (State or Country). md.

12-MAIDEN NAME OF MOTHER Geraldine Mayo.

13-BIRTHPLACE OF MOTHER (State or Country). md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Hardesty

(Address) 2734 Tivoly ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1917, to Oct 15 1917, that I saw h— alive on Oct 15 1917 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy

..... (Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) Dec yrs. ..... mos. ..... ds.

(Signed) H Rutenberg M. D.

Oct 16, 1917 (Address) 1228 E Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem — DATE OF BURIAL. Oct 18, 1917

20-UNDERTAKER H M Cook — ADDRESS York Road

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9299 — D 9299

CERTIFICATE OF DEATH.

19 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Sinai Hospital, Mount St., (WARD) 19

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Gatchell

(Residence in Baltimore: No. 1423 W. Lombard St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Sing'l

6-DATE OF BIRTH, Dec 9, 1846 (Month) (Day) (Year)

7-AGE, 71 yrs. — mos. 7 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Samuel N. Gatchell

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Eliza J. Murphy

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hettie M. Gatchell

(Address) 1423 W. Lombard St

15-

ROBERT E. KRAUTZ
OCT 17 1917
Local Registrar, District

Filed ....., 191.. .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1917, to Oct 16 1917, that I saw h[illegible] alive on October 15 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

1. Pulmonary Embolism

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(Duration) 2 yrs. ...mos. ...ds.

(Signed) C. R. Duvall M. D.

Oct 16, 191.. (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Oct. 19, 1917

20-UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9300

CERTIFICATE OF DEATH.

151 D 9300

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 E Biddle ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Baer

(Residence in Baltimore: No. 620 E Biddle St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	white	Single

6-DATE OF BIRTH, 10 (Month) 17 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 3 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm Baer

11-BIRTHPLACE OF FATHER (State or Country), Mahanoy City Pa

12-MAIDEN NAME OF MOTHER Hazel McConnell

13-BIRTHPLACE OF MOTHER (State or Country), St Johns Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Baer

(Address) 620 E Biddle St

15-

Filed....., 191.....

OCT 17 1917 ROBERT B. KRAUTER Registrar. BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-17 1917, to 10-17 1917, that I saw h[illegible] alive on 10-17 1917, and that death occurred, on the date stated above, at 3.18 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth 5-6 mo

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration)....yrs....mos....ds.

(Signed) D. Brandt Wilson M. D.

10-17, 191.. (Address) 620 E. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT 17 1917, 191...

20-UNDERTAKER	ADDRESS
Commissioner Health.	

PAT. APP. FOR.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9301 — 120 — D 9301

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jamie Rice

(Residence in Baltimore: No. 1105 Hattins St Watson St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE ~~Black~~ White (Write the word.)

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Nov. 13, 1874
(Month) (Day) (Year)

7-AGE, 37 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Gen'l

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Boyle Williams

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Jamie Rice

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hosp.

(Address) Calvert St.

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 14, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 191..., to Oct. 14 191..., that I saw him alive on Oct 14 191..., and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uremic Poisoning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward L. Beuth M. D.

Oct 17, 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State 0 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1105 Hattins St

Former or usual residence 1105 Hattins St

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, OCT 17 1917, 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

OCT 17 1917 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D 9302

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 9302

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Tyley

(Residence in Baltimore: No. 812 E. Pratt St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Not Known (Month), 1 (Day) (Year)

7-AGE, 60 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Q 040

9-BIRTHPLACE. (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11 1917, to Oct. 11 1917, that I saw him alive on Oct. 11 1917, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Not Known yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward D. Smith M. D.

Oct. 11, 1917 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ½ ds. In the State 40 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? 812 E. Pratt St.

Former or usual residence 812 E. Pratt St.

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. OCT 17 1917, 191...

20-UNDERTAKER

ADDRESS

OCT 17 1917 ROBERT R. STRAUSS

Commissioner Health.

25

Per. Wm. E. WOODAL

Spec.—8-24-14—M. & T.—2000 Bks.

D 9303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9303

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bd. General Hospital St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Fintzel

(Residence in Baltimore: No. 27 S. Calhoun St. St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 20, 1879.
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Bootmaker

9-BIRTHPLACE, (State or Country), New York City

PARENTS.

10-NAME OF FATHER, do not Know

11-BIRTHPLACE OF FATHER (State or Country), New York, N.Y.

12-MAIDEN NAME OF MOTHER do not Know

13-BIRTHPLACE OF MOTHER (State or Country), do not Know

14-THE ABOVE IS TRUE TO THE ~~BEST~~ OF MY KNOWLEDGE.

(Informant) John J. Fahey

(Address) 318 Light St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10- 1917, to Oct. 16 1917, that I saw him alive on Oct 16 1917, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Wm. Taylor M. D.

Oct 16-, 191 7. (Address) Bd. General Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State 2 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home.

Former or usual residence 27 S. Calhoun St.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Oct 18, 1917

20-UNDERTAKER John J. Fahey & Sons — ADDRESS 318 Light St

OCT 17 1917 ROBERT B. KRAUTER Registrar Bureau Vital Statistics

Spec.—8-24-14—M. & T.—2000 Blks.

P D 9301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 9301

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 Fremont Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Rausch

(Residence in Baltimore: No. 2416 Fremont Ave St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~ MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 5th, 1878
(Month) (Day) (Year)

7-AGE, 89 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ernst Rausch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Rausch

(Address) 2416 Fremont Ave

15-

Filed ....., 191.....

OCT 17 1917 ROBERT H. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Oct 16 1917, that I saw h[illegible] alive on Oct 15 1917, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

[illegible] Pneumonia

[illegible]

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ....yrs....mos....ds.

(Signed) R Irvine Hill M. D.

Oct 16, 191 7 (Address) 1433 Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Oct 18th, 1917.

20-UNDERTAKER J. B. Kilgus

ADDRESS 2236 Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 93305 — 119 — D 93305

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Woodyear Place ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Chase

(Residence in Baltimore: No. 717 Woodyear Place St.; 1 yrs., mos. ds.) 8 or 9 yrs in City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Single

6-DATE OF BIRTH, Aug (Month) 11 (Day), 1893 (Year)

7-AGE, 24 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): St Marys Co Md.

PARENTS.

10-NAME OF FATHER, George Chase.

11-BIRTHPLACE OF FATHER (State or Country), Charles Co Md.

12-MAIDEN NAME OF MOTHER Mary Cosberry

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chase

(Address) 1713 Division St Jas Worthy

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to Oct 13 1917, that I saw h[illegible] alive on Oct 13 1917, and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Wm H Wright M. D.

Oct 14, 1917 (Address) 1209 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL, OCT 17 1917

20-UNDERTAKER Commissioner Health.

ADDRESS

WM. E. WOODALL

Spec.—8-24-14—M. & T.—2000 Bks.

D 9306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D 9306

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD) REGISTERED NO. C

2-FULL NAME Infant Riggs

(Residence in Baltimore: No. University Hospital St.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 9 29 1917
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 18 ds.

If LESS than 1 day, 0 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Hare

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Anita Riggs

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C. Morris M.D.

(Address) University Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9 29 1917, to 10-16 1917, that I saw h.. alive on 10 16 1917, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital debility.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth,

(Duration) yrs. mos. ds.

(Signed) J. C. Morris M. D.

10-16..., 191.7 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct 17, 191.7

20-UNDERTAKER Samuel Hemsley ADDRESS 5 & W Biddle

OCT 17 1917 ROBERT B. BEAUTEN

93

Lillian M. Heath

D 9307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9307

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2742 N. Lafayette St.; 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian M Heath

(Residence in Baltimore: No. 2742 N. Lafayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct. (Month) 20 (Day), 1916 (Year)

7-AGE, ...yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Virgil Heath

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lillian Wright

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 2724 N. Lafayette

15-

OCT 17 1917 ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Pneumonia

Gastro Intestinal (Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Indigestion

(Duration) yrs. 10 mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 17, 1917 (Address) 819 E. East

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Oct. 18, 1917

20-UNDERTAKER F. A. Salause — ADDRESS 703 Hanover

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9308

CERTIFICATE OF DEATH.

81 ✓ 9308 D 9308

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Newington Ave., ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Blondheim,

(Residence in Baltimore: No. 714Newington St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 30th. (Day) 1848. (Year)

7-AGE, 69 yrs. 3 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired, 66 ✓
(b) General nature of industry, business, or establishment in which employed (or employer): Clthg. merchant,

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herz Blondheim,

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Goodman,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D.Blondheim,

(Address) 714 Newington,

15-

Filed ....., 191.....

OCT 17 1917 ROBERT S. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 16 (Day) 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct. 16 1917, that I saw h— alive on Oct 16 1917, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) I.Strauss M. D.

Oct 16, 1917. (Address) 1720 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto. Hebrew.	Oct. 18th, 1917.

20-UNDERTAKER Harry Goodman

ADDRESS 1128 Myrtle Ave.

D 9309 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 9309

CERTIFICATE OF DEATH.

167 D 9309

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Stoll

(Residence in Baltimore: No. 1508 Ashland ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	child

6-DATE OF BIRTH, Aug. 13 1910, 1 (Month) (Day) (Year)

7-AGE, 7 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer)..... ooo

ooo

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Adolf Stoll

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stoll

(Address) 1508 Ashland ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16 1917, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns accidental while building fire in stove

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Oct 17 1917, 191... (Address) N E Dist

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Oct 17, 191

20-UNDERTAKER Grand Coach & Sons

ADDRESS 1500 Ashland Ave

important. See instructions on back of certificate.

D 9310 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9310

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 25 First Maryland St.; W. 7 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo Welsh,

(Residence in Baltimore: No. 40 Lee St.; 30 yrs., 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ... Jan (Month) 19 (Day), 187 (Year)

7-AGE, 30 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0.19

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Leo r Welsh

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Anna Conn

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kost

(Address) 932 Monument

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

50 hrs Ill Duration

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno F Gurley M. D.
(Coroner)

Oct 16 1917 (Address) 11 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? At Baugh Chemical Co

Former or usual residence Canton

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, Oct 17, 19..

20-UNDERTAKER M. J. Elgin — ADDRESS 1462 Light

481

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9311

CERTIFICATE OF DEATH.

150 D 9311

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Gorsuch Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Schweizer

(Residence in Baltimore: No. 903 Gorsuch ave St.; ..... yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October 17, 1917
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 20 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. md

PARENTS.

10-NAME OF FATHER, Gilbert L. Schweizer

11-BIRTHPLACE OF FATHER (State or Country), Balto. md

12-MAIDEN NAME OF MOTHER Minnie Engelmeyer

13-BIRTHPLACE OF MOTHER (State or Country), Balto. md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. G. L. Schweizer.

(Address) 903 Gorsuch Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 191 7, to Oct 17 191 7, that I saw h— alive on Oct 17 191 7, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

.....
Cirrhosis liver
.....
..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt. P. Jakubik M. D.

Oct 17, 191 7 (Address) 1318 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Oct 18, 191 7

20-UNDERTAKER Penny Hoerth & Son

ADDRESS 1301 E Eager

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9312

CERTIFICATE OF DEATH.

151 ✓ D 9312

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Mura St ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Schimunek

(Residence in Baltimore: No. 2201 Mura St St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 17, 1917
(Month) (Day) (Year)

7-AGE, ..yrs..mos..ds.

If LESS than 1 day, 1 hrs. or ..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Schimunek

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Francis M Havlot

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Schimunek

(Address) 2201 Mura St

15-

Filed ....., 191..
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 17 1917, that I saw h alive on Oct 17 1917, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(5½ mos Foetus)

(Duration) ..yrs..mos..ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..yrs..mos..ds.

(Signed) D. P. Lerch M. D.

Oct 7, 191.7 (Address) 1306 E Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Oct 18, 1917.

20-UNDERTAKER Geo M. Kirk

ADDRESS 811 W Wolfe

Spec.—8-24-14—M. & T.—2000 Bks.

D 9313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 V

D 9313

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Chapel ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Grossmann

(Residence in Baltimore: No. 424 N. Chapel St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) Oct (Day) 17, (Year) 1917

7-AGE, ... yrs. ..... mos. ..... ds. | If LESS than 1 day, 2 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank C. Grossmann

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Catherine Schwartzer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE ~~TO~~ THE BEST OF MY KNOWLEDGE.

(Informant) Kate M. Grossmann

(Address) 424 N. Chapel

15-

OCT 18 1917 HARRY C. ANDREWS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 17 191 , to Oct 17 191 , that I saw her alive on Oct 17 191 , and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity (Premie) Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Glover M. D.

10/17, 191 7. (Address) 413 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Oct 18, 1917

20-UNDERTAKER Geo M. Sivers | ADDRESS 811 N. Wolfe

Spec.—5-19-13—M. & T.—500 Bks.

D 9314

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 9314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1734 Poplar Grove ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada ~~Est~~ Virginia Buncker

(Residence in Baltimore: No. 1734 Poplar Grove St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec (Month) 12 (Day), 1889 (Year)

7-AGE, 27 yrs. 10 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Adm. E. Macneal

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Lydia G. Boston

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia G. Macneal

(Address) 1734 Poplar Grove

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Oct 16 1917, that I saw her alive on Oct 16 1917, and that death occurred, on the date stated above, at 4.10A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ernest H. Kalm M. D.

Oct 17, 191 7 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem

DATE OF BURIAL. Oct 19, 1917

20-UNDERTAKER Albert C Kulb

ADDRESS 221 N Broadway

D 9315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 9315

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Host ST.: 6 WARD)

2-FULL NAME Moses Goldberg

(Residence in Baltimore: No. 109 N. Bond St.: yrs., 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1855 (Year)

7-AGE, 62 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wine 045
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER, Abraham Goldberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rosa —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore

15- Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquisition (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage into pons
Bulbar Capsule of Brain
(Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Thrombosis of Basilar
(Duration) yrs. mos. ds.

(Signed) Henry Byrd Lindsay M. D.
(Coroner)
Oct 18, 1917. (Address) 1610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Ellis Island

Former or usual residence 109 N. Bond St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 10/18, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9316

CERTIFICATE OF DEATH.

64 D 9316

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 W Franklin ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda E. Piquett

(Residence in Baltimore: No. 719 W Franklin St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Widow

6-DATE OF BIRTH. Mar 1 [illegible], 1856
(Month) (Day) (Year)

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William Stansbury

11-BIRTHPLACE OF FATHER (State or Country). Ia.

12-MAIDEN NAME OF MOTHER Zellers

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Piquett MD

(Address) 701 N. Carrollton Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 16th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1917, to Oct 16th 1917, that I saw h[illegible] alive on Oct. 16th 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) Howard Piquett M. D.

Oct 17th, 191.. (Address) 701 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Oct 19th, 191..

20-UNDERTAKER Joseph D. Cook ADDRESS 1003 Madison St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9317. HEALTH DEPARTMENT—CITY OF BALTIMORE D 9317.

CERTIFICATE OF DEATH.

REGISTERED NO. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 2612 Fait St. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Margaret Weber

(Residence in Baltimore: No. 2612 Fait Ave.; 4 yrs., 4 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 4 (Day), 1913 (Year)

7-AGE, 4 yrs. 4 mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H. Weber

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary C. Hartline

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Weber

(Address) 2612 Fait Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 4th 191 7, to Oct 17 191 7, that I saw h[illegible] alive on Oct 16th 191 , and that death occurred, on the date stated above, at 3:35 a. m.

The CAUSE OF DEATH* was as follows:

Cloud Bronchitis

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (Duration) ... yrs. ... mos. 2 ds.

(Signed) H. L. Reinhardt M. D.

Oct 17, 191 7 (Address) 5100 Aberdeen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER Zirkes & Zirkes

ADDRESS 1739 E. Eager

D 9318 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9318

164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 125 Pearl ... St.: 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene - Smith

(Residence in Baltimore: No. 125 N Pearl St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown ..... (Month), 1 ..... (Day) (Year)

7-AGE, 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —

070

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Carter

(Address) 125 N Pearl.

15-

OCT 13 1917 HARRY D. GROSNICKLE

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Carcinoma

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Dr. Fiscale M. D.
(Coroner)

Oct 15, 1917. (Address) 312 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

.....

Former or usual residence Lisbon Road

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Oct 19, 19...

20-UNDERTAKER Charles B. Jones

ADDRESS 124 Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Division ST.: 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Myrtle Carter

(Residence in Baltimore: No. 1813 Division St.; 4 yrs., 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	Colored	Infant

6-DATE OF BIRTH, June 22, 1913
(Month) (Day) (Year)

7-AGE, 4 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Robert Carter

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Anna Berry

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Carter

(Address) 1813 Division St.

15-

Filed....., 191.....

Registrar.

OCT 18 1917 REGIST'R OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1917.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 14 1917, to Oct 18 1917, that I saw her alive on Oct 18 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria toxaemia

(Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) Infection

(Duration) ....yrs....mos....ds.

(Signed) Edw. Short M. D.

Oct. 18, 1917 (Address) 1812 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Oct 21 1917

20-UNDERTAKER George H. Hellen ADDRESS 1631 Edmondson Ave

3 P.M.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9320

CERTIFICATE OF DEATH.

120 ✓

D 9320

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 North Calvert St. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bond

(Residence in Baltimore: No. 1125 N. Calvert St. St.; 71 yrs., 5 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 11, 1846 (Month), 1 (Day)

7-AGE, 71 yrs. 5 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Commission Mer.
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Bond

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Elizabeth Crosby

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carroll T. Bond

(Address) 1125 N. Calvert St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 15 1917, to Oct 15 1917, that I saw him alive on Oct 15 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Asthma

Pulmonary — Tuberculosis —

(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation Acute

(Duration) Few hours yrs. mos. ds.

(Signed) Chas. Latrobe M. D.

Oct 16, 1917. (Address) 132 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	10/16....., 1917.
20-UNDERTAKER Henry W. Means & Son	ADDRESS 805 N. Calvert St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9321 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 9321

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 W. Fayette ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Eugene Chapman Jr

(Residence in Baltimore: No. 1502 W. Fayette st St. 28 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, August (Month) 10 (Day), 1888 (Year)

7-AGE, 29 yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Head Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): Cutter

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm Edward Chapman

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER, Lucia A. Childress

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Chapman

(Address) 1502 W. Fayette st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1916, to Oct 17 1917, that I saw h[illegible] alive on Oct 16 1917, and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) None

(Duration) .... yrs. .... mos. .... ds.

(Signed) Henry E. Wade M. D.

Oct. 17, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Oct. 19, 1917.

20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9322

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 W Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M Cooney

(Residence in Baltimore: No. 1719 W Lombard St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, July 23, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. 2 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Higgins

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary McFadden

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Cooney

(Address) 1719 W Lombard

15-

Filed....., 191.....
Registrar.

OCT 18 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1916, to Oct 16 1917, that I saw h- alive on Oct 16 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(Duration) yrs. mos. ds.

(Signed) Wm Thos O'Neil M. D.

10 18, 191 7. (Address) 541 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, 10/20, 191 7.

20-UNDERTAKER Geo A Fahy — ADDRESS Fulton Ave

D 9323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 9323

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Topper

(Residence in Baltimore: No. 1610 Hillsin Ave St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June 22, 1877
(Month) (Day) (Year)

7-AGE, 40 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Jos Topper

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Mary Bushman

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J W Topper

(Address) 1610 Hillsin Ave

15-

Filed....., 191.....
Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 4th Vertebra
accidental
Caused by falling off load
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) T. Edw Smith M. D.
(Coroner)

Oct 18, 1917 (Address) 710 Eight St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Camp Meade

Former or usual residence 1610 Hillsin Ave

19-PLACE OF BURIAL OR REMOVAL, Evans Presbyterian Cem. DATE OF BURIAL, 10/19, 1917

20-UNDERTAKER Jos A Farley ADDRESS Fulton & Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 9324 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

105-D 9324

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Ryan

(Residence in Baltimore: No. 1028 N. Eden st St.: 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 26, 1880 (Month) (Day) (Year)

7-AGE, 37 yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Monotype Operator
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] 086

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Richard Ryan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Hall

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W J Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

OCT 18 1917 HARRY C. BREWSTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 6 1917, to Oct 17 1917, that I saw her alive on October 17 1917, and that death occurred, on the date stated above, at 11.24 p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Kidneys + colitis

Autopsy (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) 1 yrs. mos. 1 ds.

(Signed) Chas Bloom Jr MD

Oct 18, 1917 (Address) Johns Hopkins Hosp M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1028 N. Eden St.

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa. DATE OF BURIAL, October 19 1917.

20-UNDERTAKER Henry Storck Son ADDRESS 130 E Eager st

Spec.—8-24-14—M. & T.—2000 Bks.

D 9325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9325

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. Paul ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Connor

(Residence in Baltimore: No. 611 Walpert Ave St.; 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1866 (Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) St. Joseph's Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 17 1917, that I saw her alive on Oct 17 1917, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H Muthel M. D.

Oct 18, 1917. (Address) St Joseph Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State Lifetime yrs. mos. ds.

Where was disease contracted, if not at place of death? 611 Walpert Ave

Former or usual residence 611 Walpert

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem DATE OF BURIAL, Oct 20 1917

20-UNDERTAKER Chas. B. Evans & Son ADDRESS 1111 Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 9326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Saint Paul Street ST.; 11 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma May Patterson

(Residence in Baltimore: No. 1039 St. Paul Street. (Baltimore City or County) St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 25th (Day) 1857 (Year)

7-AGE, 65 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) At home 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Cagett

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER R. G. W. Daniels

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Hall Harris.

(Address) Title Building, Baltimore

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17 (Month) 1917 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 5/7 191..., to Oct 17 1917, that I saw h.r alive on Oct 17 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

.....

Chronic interstitial nephritis

..... (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) T. H. E. Prentiss M. D.

Oct. 18, 1917. (Address) 634 Gorsuch Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Oct. 19, 1917.

20-UNDERTAKER A. Wm. Jenkins Sons Co.

ADDRESS McCulloh & Orchard Sts Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9327.

CERTIFICATE OF DEATH.

79 ✓ D 9327

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha O'Dell

(Residence in Baltimore: No. Lexington & Calhoun Sts St.; 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 83 yrs. - mos. - ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 00

9-BIRTHPLACE, (State or Country), New York State

PARENTS.

10-NAME OF FATHER, Edwin O'Dell

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella J. Jones

(Address) Matron

15-

OCT 18 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1917, to Oct 17 1917, that I saw h alive on Oct 16 1917, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia Contributory Degeneration of Heart

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) yrs. 3 mos. ds.

(Signed) H. Norwood M. D.

Oct 18, 1917, (Address) 939 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. - mos. - ds. In the State 50 yrs. - mos. ds.

Where was disease contracted if not at place of death? Aged Women Home

Former or usual residence Aged Women Home

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER Leo Smith

ADDRESS 1002 W Fayette

D 9328

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

50

D 9328

REGISTERED No. C

1 PLACE OF DEATH

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 2125 Mt. Holly ST. 15 WARD)

2-FULL NAME Mary E. Childs

(Residence in Baltimore: No. 2125 Mt Holly St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: December (Month) 3 (Day), 1837 (Year)

7-AGE: 79 yrs. 10 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: James Lusk

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Pengry

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Childs Jones

(Address) 1704 Linden Ave

15.

Filed ..... , 191 .....

REGISTRAR

OCT 18 1917

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1916, to, Oct 17th 1917, that I saw h— alive on Oct 17th, 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Interval

Chronic Interstitial Nephritis, Chronic Valvular Disease

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Senile

(Duration) yrs. mos. ds.

(Signed) William H. Knapp M. D.

Oct 18th, 1917 (Address) 1 E. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 20, 1917

20-UNDERTAKER: Geo F Smith

ADDRESS: 1000 N Fayette St

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9329

CERTIFICATE OF DEATH.

19 D 9329

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. St.; 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia Chinn

(Residence in Baltimore: No. 1612 Latrobe Street St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	...rried

6-DATE OF BIRTH. ..... Sept. 30, ..., 1873
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 0 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... General 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Chinn

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Record.....

(Address)....Mercy Hospital.....

15-

Filed....., 191.....

Registrar.

OCT 18 1917 ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct. 16, ..., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 7 Oct. 16, 191 7;
that I saw her alive on Oct. 16, 191 7.
and that death occurred, on the date stated above, at 11:45 m.
The CAUSE OF DEATH* was as follows:

.....
Mitral Stenosis
.....
.....
..... (Duration) Do not know yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward L. Smith M. D.

Oct. 17, 191 7 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State 50 yrs. -- mos. -- ds.

Where was disease contracted, if not at place of death? 1612 Latrobe St.

Former or usual residence 1612 Latrobe St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery.	Oct. 19, 1917.
20-UNDERTAKER	ADDRESS
Felix B. Pye	1028 Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

D 9330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9330

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3125 Elliott ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bogucki

(Residence in Baltimore: No. 3125 Elliott St.; 1 yrs., 7 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 27, 1915
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Grocer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Michael

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Rzghowski

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael C.

(Address) 3125 Elliott St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17, 1917.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 9 1917, to Oct 17 1917., that I saw h[illegible] alive on Oct 16. 1917, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration)....yrs....mos....ds.

(Signed) C. L. Mees, M. D.

10/24/, 1917. (Address) 1138 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Oct. 19, 1917

20-UNDERTAKER Stephen J. Kalkowski — ADDRESS 1019 Sk[illegible]

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9331

CERTIFICATE OF DEATH.

104 D 9331

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Gough ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Lazzaro

(Residence in Baltimore: No. 1517 Gough St.; ... yrs., 11 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. 12th, 1916 (Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 6 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE. (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Frank Lazzaro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Buskey

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Lazzaro

(Address) 1517 Gough St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13, 1917, to Oct 18, 1917, that I saw h[illegible] alive on Oct 17, 1917, and that death occurred, on the date stated above, at 6:45 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Pleurisy

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry Smith Austin M. D.

Oct 18, 1917 (Address) 1401 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent's — DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER Arnold Lippe Son — ADDRESS 330 S. Bond St.

OCT 19 1917 ROBERT E. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9332

CERTIFICATE OF DEATH.

D 9332

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Stanford ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel J. McCormick

(Residence in Baltimore: No. 1102 Stanford ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. April 23, 1864.
(Month) (Day) (Year)

7-AGE, 53 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocery & Feed
(b) General nature of industry, business, or establishment in which employed (or employer)..... Store 045

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel J. McCormick

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Winefred Mallon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes D. Kavanaugh

(Address) 1102 Harford Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1st 1917, to October 16, 1917, that I saw him alive on October 16, 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Meningo cal rain disease mast. acute

(Duration) ....yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) G. G. Russ M. D.

Oct. 17, 1917. (Address) ~~1102 E. Baltimore~~ N. E. Charles & Preston Sts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral	Oct. 19, 1917.

20-UNDERTAKER	ADDRESS
H. C. Wadefield	9 E. Fremont Ave

Important. See instructions on back of certificate.

D 9333 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓ D 9333

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No..... 903 Plum Alley. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice I Netter.(C)

(Residence in Baltimore: No. 903 Plum Alley St.; yrs., 5 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single.

6-DATE OF BIRTH: May, 1st. 1917. (Month) (Day) , 1 (Year)

7-AGE: 5 yrs. 16 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Charles Netter.(C)

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Edith Barnes.(C)

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Netter.(C)

(Address) 903 Plum Alley.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th. 1917. (Month) (Day) , 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(unknown)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Wm. M. Reinhardt M. D.
(Coroner.)

Oct. 18, 1917 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Ct

DATE OF BURIAL: Oct 19 1917

20-UNDERTAKER: J. L. Brown & Son

ADDRESS: 1801 Druid

CAUSE OF DEATH must be plain, definite and important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9334

CERTIFICATE OF DEATH.

28 ✓ D 9334

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Pebble Court ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Brown

(Residence in Baltimore: No. 817 Pebble court St.; 43 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day), 1874 (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stone rubber
(b) General nature of industry, business, or establishment in which employed (or employer) (laborer) 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas H. Brown,

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Turner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Brown

(Address) 63 W. West St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October ..... (Month) 17 ..... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 24 1917, to Oct 13th 1917, that I saw him alive on October 16 1917, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Bright's

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. Guy Bowley M. D.

10/18/17, 191.. (Address) 136 W. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn St — DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER C. L. Brown and Son — ADDRESS 108 N. Monty

Important. See instructions on back of certificate.

ROBERT S. KRAUTER

OCT 18 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 9335 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9335

CERTIFICATE OF DEATH.

+109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp St.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anderson Davenport Jr

(Residence in Baltimore: No. Sparrows Point St.; ....yrs., ...mos. 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October 8, 1874
(Month) (Day) (Year)

7-AGE, 43 yrs. ....mos. ....da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co. 040

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER Anderson Davenport Sr

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Davis

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Taylor Davenport

(Address) 717 E. Sparrows Pt

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 18 1917, that I saw him alive on Oct 18 1917, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Volvulus

(Duration) ....yrs. ....mos. 1 ....da.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. 1 ....da.

(Signed) J. M. Dunlap M. D.

Oct 18, 191.. (Address) Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence Sparrows Point. (Md)

19-PLACE OF BURIAL OR REMOVAL, Reynolds Va — DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER Samuel W Swanson — ADDRESS 1400 Market St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9336

CERTIFICATE OF DEATH.

104 ✓ D 9336

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Elm ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Franklin Dandy

(Residence in Baltimore: No. 3808 Elm Ave St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Single

6-DATE OF BIRTH. March 22, 1917
(Month) (Day) (Year)

7-AGE. 6 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Howard F Dandy

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Rosie McCullough

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard F Dandy

(Address) 3808 Elm

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10th 1917, to Oct 18th 1917, that I saw h...alive on Oct 17 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis Colitis

(Duration)..... yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) —

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) W. A. Fort M. D.

Oct 7, 191.. (Address) 12 E 35th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Pine Grove Cem	Oct 20, 1917
20-UNDERTAKER	ADDRESS
Edw Roy Stifflee	844 N 36th St

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9337

CERTIFICATE OF DEATH.

8V D 9337

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 So Parrish ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas E Brady

(Residence in Baltimore: No. 430 So Parrish St.; 1 yrs., 4 mos. 26 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 21 (Day), 1916 (Year)

7-AGE, 1 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore MD

PARENTS.

10-NAME OF FATHER, Chas F Brady

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Louise Landon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas F Brady

(Address) 430 S Paca

15-

Filed OCT 18 1917, 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 17 1917, that I saw h[illegible] alive on Oct 17 1917, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Pertussis ?

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tonsulitis

Convulsions (Duration) yrs. 3 mos. 3 days

(Signed) Dr. D. Mahoney M. D.

Oct 18, 1917 (Address) 34 So Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Oct 17, 191..

20-UNDERTAKER Joseph K Cook

ADDRESS 1003 N Eutaw St

important. See instructions on back of certificate.

D 9338

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 9338

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W. Henrietta st. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J. Corcoran.

(Residence in Baltimore: No. 105 W. Henrietta st. St.; 37 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: ~~Male~~

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept. (Month) (Day), 1880 (Year)

7-AGE: 37 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: James J. Corcoran

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Elisabeth Sullivan

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Beck

(Address) 105 W. Henrietta

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. 17/17. (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1/17, 191, to, Oct. 17/17. 191, that I saw h... in alive on Oct. 15/17. 191, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 2 yrs mos. ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed) [signature] M. D.

Oct. 17/17. 191 [Address] 933 Hanover st

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Oct. 19 191 7

20-UNDERTAKER: M. A. Flynn

ADDRESS: 1432 Light St.

state CAUSE OF DEATH in plain terms, so that it may be understood by any physician. TION is very important. See instructions on back of certificate.

D 9339

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C 9339

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2118 W. Saratoga St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R Taylor

(Residence in Baltimore: No. 2118 W. Saratoga St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: August 18, 1886 (Month) (Day) (Year)

7-AGE: 31 yrs. 2 mos. 30 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Forman in clothing
(b) General nature of industry, business, or establishment in which employed (or employer): factory

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: John Taylor

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Flora Jackson

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha M. Taylor

(Address) 2118 W. Saratoga St

15-

OCT 18 1917 ROBERT R. KRAUTER

Filed ....., 191... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 17th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1917, to Oct 17th 1917, that I saw him alive on Oct 17, 1917, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

General paresis

(Duration) ..... yrs. 4 mos. ..... ds

Contributory (SECONDARY): Convulsion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benjamin K Adrn M. D.

Oct 18, 1917 (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct 20, 1917

20-UNDERTAKER: Geo. A. Gerber — ADDRESS: Baltimore Md

N. B.—EVERY BLANK must be filled out completely. Data must be obtained from informant if not from personal knowledge. If unknown, state so. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

P 9340

CERTIFICATE OF DEATH.

20 D 9340

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Barry Thomas James Bill Jones

(Residence in Baltimore: No. 1929 W. Lanvale St.; 11 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 18, 1836
(Month) (Day) (Year)

7-AGE, 81 yrs. 7 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel Jones

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nancy Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Jones

(Address) 1929 W. Lanvale

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29 1917, to Oct 17 1917, that I saw him alive on Oct 17 1917, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Chr. interstitial nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Homer L. Todd M. D.

Oct 17, 1917. (Address) 935 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Oct. 19 1917

20-UNDERTAKER Leo A. Gerber — ADDRESS Baltimore

important. See instructions on back of certificate.

D 9341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9341

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 S. Frederick ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh Gross

(Residence in Baltimore: No. 226 S. Frederick St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Stemmer
(b) General nature of industry, business, or establishment in which employed (or employer): 049

366

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15-

Filed ....., 191.....

OCT 19 1917 HARRY O. ANDERSON Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, found that said deceased came to..... death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

(a) Coronary Thrombosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sudden

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Kelly (Coroner.) M. D.

Oct 17, 1917 (Address) 1627 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetary	Oct 19, 1917
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	506 East St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9342

CERTIFICATE OF DEATH.

119 D 9342

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N. Montford St.; 12 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hammond.

(Residence in Baltimore: No. 227 N. Montford ave. St.: life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, oct (Month) 10 (Day), 1875 (Year)

7-AGE, 42 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Hammond

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Peck

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hammond

(Address) 227 N Montford ave

15-

Filed OCT 19 1917, 191..., HARRY G. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, oct (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1917, to Oct. 18, 1917, that I saw h[illegible] alive on Oct. 17, 1917, and that death occurred, on the date stated above, at 11 15 a.m.

The CAUSE OF DEATH* was as follows: Acute Pancreatic Necrosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) yrs. 8 mos. ds.

(Signed) [illegible] M. D.

10/18/17, 191... (Address) 152 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arbury cemetery DATE OF BURIAL, oct 22 1917

20-UNDERTAKER Milton Davis ADDRESS 413 N Eden St

important. See instructions on back of certificate.

D 9343

D 9343 157 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 S. Ann ST.: 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Bigby Nistubroz.

(Residence in Baltimore: No. 225 S. Ann St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 17 (Day), 1917 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 2 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Andrew Nistubroz

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland

12-MAIDEN NAME OF MOTHER Josephine Kozimska

13-BIRTHPLACE OF MOTHER (State or Country), Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Nistubroz

(Address) 225 S. Ann St.

15- —

Filed....., 191.....

OCT 18 1917 ROBERT R. KRAUTER

OCT 19 1917 Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquisition (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration)....yrs....mos....ds.

(Signed) Percy Ryan Dunsay M. D. (Coroner.)

Oct 18, 1917 (Address) 16 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Stanislaus	Oct 19th, 1917.
20-UNDERTAKER W. F. Sodowski	ADDRESS 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9344

CERTIFICATE OF DEATH.

40 D 9344

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3933 Roland Av St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Brooks

(Residence in Baltimore: No. 3933 Roland Av St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-(SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. March 12, 1845 (Month) (Day) (Year)

7-AGE. 72 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Carder in (b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Jesse Brooks

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Anne Everly

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary A Brooks

(Address) 3933 Roland Av

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1917, to Oct 17 1917, that I saw h alive on Oct 16 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach over

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Oct 17, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet

DATE OF BURIAL, Oct 19, 191...

20-UNDERTAKER A. S. Marshall

ADDRESS 350 Gay St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2[illegible]lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9345

CERTIFICATE OF DEATH.

18 ✓ D 9345

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 N. Patterson Pk ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Kidd

(Residence in Baltimore: No. 945 N. Patterson Pk ave St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct (Month) 20 (Day), 1897 (Year)

7-AGE, 19 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Charlestown S. C.

PARENTS.

10-NAME OF FATHER, Chas. H. Kidd

11-BIRTHPLACE OF FATHER (State or Country) Charlestown S C

12-MAIDEN NAME OF MOTHER Eva. Platt

13-BIRTHPLACE OF MOTHER (State or Country), S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harry Hesford

(Address) 945 N. Patterson Park Ave

15-

Filed OCT 19 1917, 191..... MARY C. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1917, to Oct 17 1917, that I saw her alive on Oct 17 1917, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Chron. C. Rheumatic Arthritis

.....

.....

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

..... (Duration) ..... yrs. 2 weeks mos. ..... ds.

(Signed) J. H. Kruse Jr M. D.

Oct. 18, 1917 (Address) 604 N. Patterson Pk Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudan Park

DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER W. S. Marshall

ADDRESS 3537 Falls Rd

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9346

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Vine ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Gross (Gross)

(Residence in Baltimore: No. 1023 Vine St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col'd	Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)

844 041

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John. Gross.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Gross

(Address) 1020 Vine St.

15-

Filed OCT 19 1917, 191. HARRY C. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 191 7, to Oct 15 191 7, that I saw h alive on Oct 15 191 7, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) J. Norwood M. D.

Oct 17 191 7. (Address) 737 W. Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Oct 17, 191 7.

20-UNDERTAKER Willett Brown ADDRESS 114 St Schroeder St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks. Shave D Berman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9347.

CERTIFICATE OF DEATH.

64 D 9347.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 W. Fayett St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shave D Berman

(Residence in Baltimore: No. 637 W. Fayette St ST.; 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 64 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Glazer

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Bass

(Address) 637 W. Fayette St

15-

OCT 19 1917 HARRY C. AN...

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 15 1917, that I saw h— alive on Oct. 15 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Oct. 16, 1917 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 637 W Fayette St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run DATE OF BURIAL, Oct 18, 191..

20-UNDERTAKER S. Friedman & Bro ADDRESS 1017 E Balto St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9348

CERTIFICATE OF DEATH.

108

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo E. Nickol

(Residence in Baltimore: No. 1112 N Central Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. (Month) 3 (Day) 1877 (Year)

7-AGE, 39 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Brass finisher
(b) General nature of industry, business, or establishment in which employed (or employer). 010

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Maurice Nickol

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Nickol

(Address) 1112 N. Central Ave

15-

Filed OCT 19 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1917, to Oct 18 1917, that I saw h[illegible] alive on Oct 18 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Influenza

(Duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) Contusion

(Duration) .....yrs. .....mos. 4 ds.

(Signed) M J Egan M. D.

Oct 18, 1917 (Address) St Jos Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Not Known

Former or usual residence Balto Md

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Oct 22,

20-UNDERTAKER Henry Storck Son — ADDRESS 1301 E

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 9349

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 N. Montford Ave ST.; 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Dreisch

(Residence in Baltimore: No. 1511 N. Montford Ave St.; — yrs., — mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October (Month) 16 (Day) 1917 (Year)

7-AGE, ...yrs....mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H. Dreisch

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Louisa M. Gill

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John H. Dreisch

(Address) 1511 N. Montford Ave

15-

Filed....., 191.....

Registrar.

OCT 19 1917 MARY C. ANDREWS

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct 19 1917, that I saw her alive on Oct 18 1917, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6½ mos Foetus

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs....mos. 3 ds.

(Signed) B. P. Herzog M.D. M. D.

Oct. 19, 1917. (Address) 1305 E Patterson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross. P. & A. A. Co. Md

DATE OF BURIAL, October 19, 1917

20-UNDERTAKER Henry Hoerle Sons

ADDRESS 1307 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9350

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 9350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 W Baare ST.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Dixon

(Residence in Baltimore: No. 715 W. Baare St.; .....yrs., 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, December 14th, 1915 (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, George B. Dixon

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Catharine Sayer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. B. Dixon

(Address) 715 W. Baare St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12th 1917, to Oct 16th 1917, that I saw him alive on Oct 16th 1917, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY, (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 2 hours

(Signed) Edw. Fiset M. D.

Oct 19, 1917. (Address) 714 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, Oct 19, 1917

20-UNDERTAKER James D. Ignatius ADDRESS 1000 Pacific St

important. See instructions on back of certificate.

D 9351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 9351

REGISTERED No. C.

1-PLACE OF DEATH,
CITY OF BALTIMORE. (No. 2012 N. Calvert St.; W. WARD)

(If death occurred in a hospitnl or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, William R. Gettinger

(Residence in Baltimore: No. 2012 N. Calvert St.; yrs. 27 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 23, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm. Gettinger

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Jennie Ruhsleun

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie Gettinger

(Address) 2012 N. Calvert St

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described nbove, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to h.. death on the dny stated nbove.

The CAUSE OF DEATH* was as follows:

Suicide.
Gas Poisoned.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)

Oct 18 1917 (Address) 1632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Oct 20, 1917.
20-UNDERTAKER	ADDRESS
Stewart-Morrow Co	108 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 ✓ D 9352

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman Hospital, ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Stouffer

(Residence in Baltimore: No. In Hospital St.; ..... yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married.

6-DATE OF BIRTH, December (Month) ..... (Day) 1847 (Year)

7-AGE, 70 yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Stauffertown Pa

PARENTS.

10-NAME OF FATHER, Samuel Stover

11-BIRTHPLACE OF FATHER (State or Country), Stauffertown Pa

12-MAIDEN NAME OF MOTHER Stouffer

13-BIRTHPLACE OF MOTHER (State or Country), Stauffertown Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Shoemaker

(Address) 1111 Carlton Terrace

15-

Filed OCT 19 1917, 191.... HARRY D. AMBLER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct 18 1917, that I saw h[er] alive on Oct 16 1917, and that death occurred, on the date stated above, at 4.40 p m.

4.30 p m. 7.40 p m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Amelia M. Clark M. D.

Oct. 18, 1917. (Address) Woman Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 1 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Shamokin Pa

19-PLACE OF BURIAL OR REMOVAL, Mountain View Cemetery Stauffertown Md. DATE OF BURIAL, Oct 21 1917.

20-UNDERTAKER John J. Cowan & Son. and ADDRESS 907 Hollins St. Stauffertown Md.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9353 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S Regester ST.; 24 WARD) REGISTERED NO. C 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Schmeisle

(Residence in Baltimore: No. 318 S. Regester St.; ....yrs., 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Feb 26, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John E. Schmeisle

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Roth.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Schmeisle

(Address) 318 S. Regester St.

15-

Filed OCT 19 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 17 1917, that I saw h— alive on Oct 17 1917, and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

..... Cerebro Pneumonia

.....

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 19, 1917 (Address) 16 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Patricks Ecm	Oct. 20, 1917

20-UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S Broadway

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9351

CERTIFICATE OF DEATH.

136 D 9351

1-PLACE OF DEATH Fred. Gen'l Hosp—

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Linden Ave & Madeira ST.; 66 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elvira Gillis

(Residence in Baltimore: No. 1212 Riggs Ave St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 14 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto - Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JOHNS HOPKINS HOSPITAL

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct - 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept-18 1917, to Oct-16- 1917, that I saw h[illegible] alive on Oct-13- 1917, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Peritonitis following Caesarian Section

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Caesarian Section

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. H. Emge, M. D.

....., 191... (Address) Med. Genl Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 28 dr. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Med. Genl Hosp.

Former or usual residence 1212 Riggs Ave

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, Oct 18 1917 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9355

CERTIFICATE OF DEATH.

104 D 9355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Burton

(Residence in Baltimore: No. Henry Watson Aid Society St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Not Known ..... (Month), ... (Day), 1 ..... (Year)

7-AGE.	If LESS than 1 day,
..... yrs. About 5 mos. ..... ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER Mary Burton

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp

15-

Filed ....., 191.....

JOHNS HOPKINS HOSPITAL

Registrar.

OCT 19 1917 ROBERT R. CARUTHERS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Oct 18 1917, that I saw h Er alive on Oct 18 1917, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

about (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward R. Smith M. D.

Oct 19, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. / mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Do not Know.

Former or usual residence Do not Know.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
	OCT 18 1917 ..... 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

Per Wm E. WOODALL

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lks.

D 9356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 120 D 9356

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S. E. Cor. Piedmont Ave. St.; & Denison St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Quinn

(Residence in Baltimore: No. Piedmont Ave. & Denison St. St.; 55 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) ----------, 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
75 yrs. - mos. - ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Mulrey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Bodkin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ella F. Quinn

(Address) Piedmont Ave. & Denison St.

15-

Filed OCT 19 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 191 7, to Oct 18 191 7, that I saw h[illegible] alive on Oct 18 191 7, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

[illegible]

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) [illegible]

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 19, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Marys Grave	10/20..., 191...
20-UNDERTAKER	ADDRESS
Henry A. Meus & Son	20 S. Eutaw St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9357.

CERTIFICATE OF DEATH.

REGISTERED NO. C D 9357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 N. Lond Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Newport

(Residence in Baltimore: No. 230 N Lond Ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 9, 1878
(Month) (Day) (Year)

7-AGE, 39 6 8 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Bottle 04

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Newport

11-BIRTHPLACE OF FATHER (State or Country), U S

12-MAIDEN NAME OF MOTHER, Ellen R Newport

13-BIRTHPLACE OF MOTHER (State or Country), U S

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C M Newport

(Address) 230 N. Lond Ave.

15-

OCT 19 1917 ROBERT R. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17, 1917.
(Month) (Day) (Year)

17) I HEREBY CERTIFY, That I attended deceased from Aug 6 1917, to Oct 17 1917, that I saw him alive on Oct 17 1917, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 3 ds.

(Signed) W. C. Krauter M. D.

Oct 18 '17, 191... (Address) 1927 N Smith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Oct 21, 191..

20-UNDERTAKER, Landecker

ADDRESS 701 E. Baltimore

Important. See instructions on back of certificate.

D 9358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 1 ✓

D 9358

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 518 S. Ann ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kolerpski;

(Residence in Baltimore: No. 518 S. Ann.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 18" (Day), 1917 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 10 min.? Instantly

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Bolestaw Kolozpski

11-BIRTHPLACE OF FATHER (State or Country), Russia Poland

12-MAIDEN NAME OF MOTHER Jadwiga Jazgunska

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bolestaw Kolozpski

(Address) 518 S. Ann St.

15-

Filed ....., 191.....

OCT 19 1917 ROBERT R. KRAUTER Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Premature Birth (Duration) ....yrs....mos....ds.

(Signed) Henry Lynn Trust M. D.

Oct 19, 1917. (Coroner.) (Address) 16 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Oct 20", 1917

20-UNDERTAKER	ADDRESS
M. F. Jankowski	705 S. Ann

N. B.—Every item of information should be carefully supplied. Also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9359
PLACE OF DEATH

CERTIFICATE OF DEATH

120 D 9359
REGISTERED No. C .....

CITY OF BALTIMORE (No. 1911 Christian St.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elnora Green

(Residence in Baltimore: No. 1911 Christian St.: 38 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 16, 1879 (Month) (Day) (Year)

7-AGE: 38 yrs. 1 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: William Green

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Maria E. Scott

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Green
(Address) 1911 Christian

15
Filed OCT 19 1917, 191 ..... ROBERT B. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 18, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1917, to Oct 17 1917.
that I saw h.. alive on Oct 17, 1917.
and that death occurred, on the date stated above, at 3:15 a m.
The CAUSE OF DEATH* was as follows:

Edema of Lungs

..... (Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm C. Colt M. D.
Oct 19, 1917 (Address) 545 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct. 20, 1917

20-UNDERTAKER: Geo. L. Schwartz & Bro — ADDRESS: 2101 Pulaski Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9360

CERTIFICATE OF DEATH.

97 D 9360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S Robinson ST.; 1st WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hanna Maye Rose

(Residence in Baltimore: No. 3431 Robinson St.; 1 yrs., 9 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 23 (Day), 1915 (Year)

7-AGE, 1 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John F Rose

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Emma E Chesser

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr J. E. Rose

(Address) 343 S Robinson St

15-

Filed OCT 19 1917, 191.....

ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 18 1917, that I saw h[er] alive on Oct 18 1917, and that death occurred, on the date stated above, at 12 20 a.m.

The CAUSE OF DEATH* was as follows:

Colo Pneumonia

(Duration) ..... yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Iannizetti M. D.

Oct 18, 1917. (Address) 2431 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Oct 20., 1917.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern Av

CAUSE OF DEATH must be stated plainly and accurately. Terms like Heart Failure, Paralysis, Convulsions, Old Age, Cancer, Tumor, Abscess, Consumption, Tuberculosis, Blood Poisoning, Dropsy, Fever, Cold, Grippe, Pneumonia, Bronchitis, Meningitis, Hemorrhage, Inflammation, Ulceration, Debility, Childbirth, Miscarriage, Infantile Diseases, Teething, Stillborn, Premature Birth, Malformation, Injury, Accident, Suicide, Homicide, Unknown, are not sufficient. Important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9361

CERTIFICATE OF DEATH

97 D 9361

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 612 Aull ..... ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Bell

(Residence in Baltimore: No. 612 Aull ..... St.: 33 yrs. 9 mos. 23 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Jan (Month) 25 (Day), 1884 (Year)

7-AGE: 33 yrs. 9 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Maryland

PARENTS

10-NAME OF FATHER: Andrew J Bell

11-BIRTHPLACE OF FATHER (State or country): Balto Maryland

12-MAIDEN NAME OF MOTHER: Elizabth Wathins

13-BIRTHPLACE OF MOTHER (State or country): Balto Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabth Bell

(Address) 612 Aull Street

15-

Filed OCT 19 1917, 191.. ..... REGISTRAR

ROBERT P. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1917, to Oct 18 1917, that I saw him alive on Oct 17, 1917, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Gilbert M. D.

Oct 19 - 1917 (Address) 2801 Gwynn Oak Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Oct 20, 1917

20-UNDERTAKER: William Cook

ADDRESS: 507 E. North Ave

D 9362 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9362

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. West Hospital ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Andreus,

(Residence in Baltimore: No. 3526 Carter Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mypos

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer). 029

9-BIRTHPLACE, (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Taylor

(Address) Annapolis Md

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bypo Amebulia
Pneumonia
(Duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Ward Carter M. D.
(Coroner.)
....., 191... (Address) Annapolis Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.

When was disease contracted, if not at place of death? Shortly prior

Former or usual residence 3526 Carter Ave

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md — DATE OF BURIAL, Oct 20 1917

20-UNDERTAKER W J Tucker — ADDRESS Annapolis Md

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9363

CERTIFICATE OF DEATH.

D 9363

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1853 W. North Ave. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabetty Schein

(Residence in Baltimore: No. 1853 W. North Ave St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Sept. 2, 1830 (Month) (Day) (Year)

7-AGE, 87 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House wife
(b) General nature of industry, business, or establishment in which employed (or employer). 000

000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabetty Hurff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lola L. Schein

(Address) 1853 W. North Ave.

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH In plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7 1917, to Oct. 18 1917, that I saw her alive on Oct. 18 1917, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Dysentery

..... (Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) 2 yrs. ....mos. ....ds.

(Signed) R. C. Metz M. D.

Oct. 19, 1917. (Address) 1903 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va. DATE OF BURIAL. Oct. 22 1917

20-UNDERTAKER Josiah Eyler ADDRESS North Ave

OCT 20 1917

D 9364

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 D 9364

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Baker St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and nomber and fill out No. 18.)

2-FULL NAME Grace M. Bucheimer

(Residence in Baltimore: No. 1616 Baker St St.; yrs. mos. 19 ds.)

N. B.—Every item of information must be answered, if unknowing, state so. Exact statement of DECEASED'S condition should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: Sept 30 (Month) 1917 (Day), 1 (Year)

7-AGE: — yrs. — mos. 19 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Clarence P. Bucheimer

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Annie V. White

13-BIRTHPLACE OF MOTHER (State or country): Fredericksburg

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence P. Bucheimer

(Address) 1616 Baker St.

15-

Filed OCT 20 1917, 191 MARY C. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 19 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19, 1917, to, Oct 19 1917, that I saw her alive on Oct 19 1917, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

3 days

Contributory (SECONDARY) Exhaustion

(Duration) immediate

(Signed), Dr. Edw. C. Burtt M D

Oct 19, 1917. [Address] 1529 N. Fulton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Oct 20, 1917

20-UNDERTAKER: Samuel Easton

ADDRESS: 916 Banna ave

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9365

CERTIFICATE OF DEATH.

120 D 9365

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 W. Saratoga ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret J. Breighner

(Residence in Baltimore: No. 815 W. Saratoga St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.): Married

6-DATE OF BIRTH: March 17, 1866 (Month) (Day) (Year)

7-AGE: 51 yrs. 7 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Frank Carney

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Breighner

(Address) 815 W. Saratoga

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Oct 19 1917, that I saw her alive on Oct 19 1917, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(Duration) 1 yrs. 5 mos. ds.

(Signed) Joseph T. Hering M. D.

Oct 19, 1917. (Address) 1812 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 22 1917.

20-UNDERTAKER W. M. Courtney — ADDRESS 230 N. Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9366 HEALTH DEPARTMENT—CITY OF BALTIMORE V D 9366

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 W Mulberry ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Wallace

(Residence in Baltimore: No. 723 W. Mulberry St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE,	If LESS than 1 day,
43 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paint Presser
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Samuel Payne

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pratt Wallace

(Address) 723 W. Mulberry St.

15-

Filed ....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Oct 18 1917, that I saw h[er] alive on Oct 17 1917, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. G. Shafer M. D.

Oct 18, 1917 (Address) 206 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Zion Cem. DATE OF BURIAL, 10-21, 1917

20-UNDERTAKER John H. Toadvine ADDRESS 142 W Hill St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+120 D 9367.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Harrison

(Residence in Baltimore: No. Rock Hall Md St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Widowed

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 72 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or estsblishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Rock Hall Md

PARENTS.

10-NAME OF FATHER, None None

11-BIRTHPLACE OF FATHER (State or Country), Rock Hall

12-MAIDEN NAME OF MOTHER None None

13-BIRTHPLACE OF MOTHER (State or Country), Rock Hall

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Harrison

(Address) Rock Hall Md

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 191.., to Oct 20 - 191.., that I saw him alive on Oct 20 - 191.., and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. M. Scott M. D.

Oct 24, 191.. (Address) 704 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death? at home

Former or usual residence Rock Hall Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Rock Hall Md	Oct 24, 191..
20-UNDERTAKER Wm F. Edwards Son	ADDRESS 1425 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9368 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor 91 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Sheeler

(Residence in Baltimore: No. Little Sisters of the Poor- St. Lif yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Antony Sheeler

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Mary Aubert

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No record 191, to 191,

that I saw him alive on Oct 16 1917,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

3 Days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Wrenn M. D.

Oct 16, 1917. (Address) 1133 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. 1 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Little Sisters of the Poor-

Former or usual residence Little Sisters of the Poor-

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents	Oct 20, 1917
20-UNDERTAKER	ADDRESS
H. C. Rudisill	1- Grant St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 9369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9369

CERTIFICATE OF DEATH.

9 + 182

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. St Josephs Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Breckenbridge

(Residence in Baltimore: No. 3401 Second ave St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
male	col	Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE. (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brakenridge

(Address) 3401 2nd Ave Catton

15-

Filed ....., 191.....

OCT 20 1917

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16. 1917, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide pistol ssot in

Abdomen Chest,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 17 1917, 191. (Coroner) (Address) N E Dist

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Cantley Md

Former or usual residence Canton Md

19-PLACE OF BURIAL, OR REMOVAL, Elsbury Cem — DATE OF BURIAL, Oct 20, 191[illegible]

20-UNDERTAKER, Samuel J Kennedy — ADDRESS 57 S Bond

Spec.—8-24-14—M. & T.—2000 Blks.

D 9370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9370

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 John al, St. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Fran, (Gray)

(Residence in Baltimore: No. 205 John al, St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) 1842 (Day) , 1 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Gray

(Address) 205 John al

15-

Filed ....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14th 1917, to Oct 17th 1917, that I saw h— alive on Oct 17th 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Colon Carcinoma

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A. Lee Ellis M. D.

Oct 20, 1917. (Address) 924 Arch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 20, 191.7

20-UNDERTAKER, Samuel Stanley

ADDRESS 578 W Fayette

D 9371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 D 9371

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bal. Gen. Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bloom (Blum)

(Residence in Baltimore: No. 530 Oxford St.: Life mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Apr. 15, 1903
(Month) (Day) (Year)

7-AGE. 14 yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS:

10-NAME OF FATHER, Aurelius Blair

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Catherine Rhetta

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 530 Oxford

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound of Brain (Homicide)

(Duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. ds.

(Signed) H. Nelson Hare M. D.
(Coroner.)

Oct. 19, 1917. (Address) 519 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos. 3 ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Stoddard Alley

Former or usual residence 530 Oxford

19-PLACE OF BURIAL, OR REMOVAL, Cathedral Entry

DATE OF BURIAL, Oct. 22, 1917

20-UNDERTAKER 960 Holland

ADDRESS 631 N. 14th

Spec.—8-24-14—M. & T.—2000 Bks.

D 9372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57D 9372

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Druid Hill Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Estelle Brown

(Residence in Baltimore: No. 1736 Druid Hill ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH Oct 19, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or 3 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Robert Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Estella Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Brown

(Address) 1726 Druid Hill ave

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 19 1917, that I saw h[er] alive on Oct 19 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Strangulation from pressure on throat

(Duration) ... yrs. ... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Strangulation from pressure on throat (Duration) ... yrs. ... mos. 1/2 ds.

(Signed) Edw J Sehrend M. D.

Oct 20, 1917. (Address) 1118 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Oct 20, 1917.

20-UNDERTAKER Groft Holland

ADDRESS 1171 Druid Hill ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2458 Greenmount ave ST.; WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Viola Shipley

(Residence in Baltimore: No. 2458 Greenmount ave St.; yrs., mos., ds.)

Ehe

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	White	Sing'l

6-DATE OF BIRTH, Oct (Month) 19 (Day), 1917 (Year)

7-AGE, 7 hours. If LESS than 1 day, 8 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ... none

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Leslie R Shipley

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Violet E Roland

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie R Shipley

(Address) 2458 Greenmount ave

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 191 7, to Oct 19 191 7, that I saw h[illegible] alive on Oct 19 191 7, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

(Duration) ... yrs. ... mos. ... ds. from birth

CONTRIBUTORY (Secondary) Premature birth

(Duration) ... yrs. ... mos. ... ds.

(Signed) Howard Kahn M. D.

..., 191... (Address) 1927 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Oct 20, 191 7

20-UNDERTAKER Graham F Walker — ADDRESS 723 N Fayette ave

CAUSE OF DEATH must be properly classified. Each statement of occupation is important. See instructions on back of certificate.

D 9374

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

102 D 9374

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 626 S Paca St ST 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia E Spence

(Residence in Baltimore: No. 626 S Paca St. St.; 2 yrs. 2 mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: ....., 1 ..... (Month) (Day) (Year)

7 AGE: ..... yrs. 9 mos. 19 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

066

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph. A Spence

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Laurue

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lydia E Spence

(Addres) 626 S Paca St

15

Filed OCT 20 1913, 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ..... (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191 , to, ..., 191 ,

that I saw h alive on ....., 191 ,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) yrs. mos. ds

Contributory (SECONDARY)

..... (Duration) yrs. mos. ds.

(Signed), ... M. D.

....., 191 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Oct 22 191 3

20 UNDERTAKER: Geo J Smith

ADDRESS: 1000 N Gay

Spec.—8-24-14—M. & T.—2000 Bks.

D 9375

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 ✓ D 9375

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 449 Augusta Av ST.) 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Steinmeddle

(Residence in Baltimore: No. 449 Augusta Av. St.: 63 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 8 (Day), 1837 (Year)

7-AGE, 80 yrs. 2 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Christian Steinmeddle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Machert

(Address) 449 Augusta Av.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 15 1917, that I saw h... alive on Oct 15 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age

(Duration) yrs. mos. ds.

(Signed) Howard W Carr M. D.

Oct 16, 191 7 (Address) Irvington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 22, 191 7

20-UNDERTAKER John L Little

ADDRESS 331 A Fremont Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9376

CERTIFICATE OF DEATH.

104 D 9376

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Seibert.

(Residence in Baltimore: No. University Hospital St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	single

6-DATE OF BIRTH, 9 (Month) 29 (Day), 1917 (Year)

7-AGE.	If LESS than 1 day,
0 yrs. 0 mos. 19 ds.	0 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): None

000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER Archer Lingenfelter

11-BIRTHPLACE OF FATHER (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Helen Seibert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C. Warnick

(Address) University Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 18 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-29 1917, to 10-18 1917, that I saw h~~im~~er alive on 10-18 1917, and that death occurred, on the date stated above, at 1.00 m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus

..... (Duration) yrs. mos. ds.

(Signed) J. C. Warnick M. D.

Oct. 18, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPI	OCT 20 1917
20-UNDERTAKER Commissioner Health,	ADDRESS

Per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificate.

D 9377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9377

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 715 Fremont ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elias Simmel

(Residence in Baltimore: No. 715 Fremont St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Col.	(single)

6-DATE OF BIRTH, Unknown, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Henry Simmel

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Celia Jeanes.

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Simmel

(Address) 715 Fremont st.

15-

OCT 20 1917

Filed....., 191.....

MARY E. ANDREWS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. L. Driscoll M. D.
(Coroner.)

Oct 20, 1917 (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 20, 1917
20-UNDERTAKER Wilbert Brown	ADDRESS 114 N Eutaw st

N.B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9378

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 N. McDonough St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Benda

(Residence in Baltimore: No. 929 N. McDonough St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, February 19th, 1859
(Month) (Day) (Year)

7-AGE, 58 yrs. 8 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Musician
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Benda

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Maria Kabratek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Marie Benda

(Address)..... 929 N. McDonough St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1917, to Oct. 19 1917.

that I saw h[illegible] alive on Oct. 19 1917.

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) — yrs. — mos. 2 ds.

(Signed) Emil Novak M. D.

Oct 20, 191.. (Address) 2621 Eastern Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cemetery

DATE OF BURIAL, Oct 21, 191.7

20-UNDERTAKER Geo. M. Zink

ADDRESS [illegible]

N. B.—Entire information called for must be given, as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9379

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 ✓ D 9379

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1834 Chapel ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Ellen Yearley

(Residence in Baltimore: No. 1834 Chapel St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Colored	Married

6 DATE OF BIRTH Oct 14, 1871 (Month) (Day) (Year)

7 AGE 46 yrs. 5 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9 BIRTHPLACE (State or country) York Pa.

PARENTS

10 NAME OF FATHER John H Lewis

11 BIRTHPLACE OF FATHER (State or country) Penn

12 MAIDEN NAME OF MOTHER Sarah A Harris

13 BIRTHPLACE OF MOTHER (State or country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. J. Elliott

(Address) 136 W Lanvale St.

15

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 19, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1917, to Oct 19 1917. that I saw h[er] alive on Oct 18 1917. and that death occurred, on the date stated above, at 7 a.m. The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Duration) yrs. 1 mos. ds

Contributory (SECONDARY) Anemia (Duration) yrs. mos. 4 ds.

(Signed) Jos Schneider M.D.

Oct 19, 1917 (Address) 330 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 22, 1917

20 UNDERTAKER H E Hughes ADDRESS 1 S Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9380

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9380

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 E. 20th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Minton

(Residence in Baltimore: No. 726 E. 20th St.; —yrs., —mos., —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. Not Known (Month), 1 (Day) (Year)

7-AGE. 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home keeper
(b) General nature of industry, business, or establishment in which employed (or employer). ...

9-BIRTHPLACE. (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Laurence Hickey

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Minton

(Address) 726 E 20

15- OCT 20 1917 REGISTRAR OF VITAL STATISTICS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7 1917, to Oct. 18, 1917, that I saw her alive on Oct. 17 1917, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) ... yrs. ... mos. 11 ... ds.

CONTRIBUTORY (Secondary) Chronic Cardiac Dilatation

(Duration) Last 4 mos. ... ds.

(Signed) Benj. D. Hamblen M. D.

Oct. 19, 1917. (Address) 1216 N. Carrollton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Catholic Cemetery

DATE OF BURIAL. Oct. 22, 1917

20-UNDERTAKER E. Flannery

ADDRESS 1938 Lafayette

N. B.—Each item of information must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9381

CERTIFICATE OF DEATH.

151

D 9381

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Corbett " 1 (Twin " 1)

(Residence in Baltimore: No. 1421 Gough St.; .....yrs., 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. September 7, 1917. (Month) (Day) (Year)

7-AGE. 0 yrs. 1 mon. 12 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Joseph Corbett

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Rose Marcus

13-BIRTHPLACE OF MOTHER (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sherman M.D.

(Address) .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 19, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Oct 19 1917, that I saw h[illegible] alive on Oct 19 1917, and that death occurred, on the date stated above, at 1 45 p.m.

The CAUSE OF DEATH* was as follows: Prematurity

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Marasmus

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) John Sherman M. D.

Oct 19, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 1 mos. 12 ds. In the State 0 yrs. 1 mos. 12 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Patients - 1424 Gough St

19-PLACE OF BURIAL OR REMOVAL. Rehoboth Cemetery

DATE OF BURIAL. Oct 21, 191..

20-UNDERTAKER J. Freeman & Bro.

ADDRESS 1107 E Baltimore St

N.B. Every CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9382

CERTIFICATE OF DEATH.

92 ✓ D 9382

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Wyanoke Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Alfred Pierce

(Residence in Baltimore: No. 612 Wyanoke Ad St.; Yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct. 7, 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. ..... mos. 13 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 966 00

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm. Pierce.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah A. Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah A. Marshall

(Address) 612 Wyanoke Ad

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 20, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 191..., to Oct 19 191...,
that I saw h... alive on Oct 19 191...,
and that death occurred, on the date stated above, at 3 a.m.
The CAUSE OF DEATH* was as follows:

Acute Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. D. Dillingham M. D.

Oct 21, 191... (Address) 1818 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct 22, 191...

20-UNDERTAKER Wm Cook ADDRESS 807 E Fayette

N. B.—Every item of information called for should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 21 1917

Dr Gillyaeus - 1818 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9383

CERTIFICATE OF DEATH.

D 9383

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert St ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Robinson

(Residence in Baltimore: No. 302 E 31st St. St.; Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1911 (Year)

7-AGE, yrs. 6 mos. 2 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Stuart H Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Gertrude Olrecht

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S H Robinson

(Address) 302 E 31st st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1917, to Oct 20 1917, that I saw h[er] alive on 20th Oct 1917, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Extroversion of Bladder

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward L Smith M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 302 E 31st St

19-PLACE OF BURIAL OR REMOVAL Woodlawn DATE OF BURIAL, Oct 22, 191

20-UNDERTAKER George A Tinley ADDRESS Fulton Ave

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9384

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 9384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 638 S. Lakewood ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. McDonald.

(Residence in Baltimore: No. 638 S. Lakewood St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Single

6-DATE OF BIRTH, Dec 28, 1876
(Month) (Day) (Year)

7-AGE, 40 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bartender
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas McDonald.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Leiman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Geo. McDonald

(Address) 638 S. Lakewood

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Oct 19 1917, that I saw him alive on Oct 16 1917, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. J. McAvoy M. D.

Oct 20, 191.7. (Address) 839 S. Ellwood Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Oct 23, 191.7

20-UNDERTAKER J. Frew McCully — ADDRESS 130 E. Fort

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9385

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Burford

(Residence in Baltimore: No. 865 Boyd St ST.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1875 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook (Domestic)
(b) General nature of industry, business, or establishment in which employed (or employer): House work.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Austin

(Address) 865 Boyd St Baltimore Md

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Oct 19 1917, that I saw her alive on Oct 19 1917, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial disease

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Brumbaugh M. D.

Oct. 19, 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State 2 yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 865 Boyd St,

19-PLACE OF BURIAL OR REMOVAL, Old Methodist Cemetery Baltimore Md — DATE OF BURIAL, Oct. 22, 1917

20-UNDERTAKER Frederick Lassahn — ADDRESS Gwynn Oak Md.

N. B.—Every item of information should be carefully applied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 D 9386

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Rosie Caplan

(Residence in Baltimore: No. 123 Aisquith St.; 36 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White / Hebrew	Married

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day) 188[illegible] (Year)

7-AGE, 36 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 637

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, George Weinberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct 20 1917, that I saw h[illegible] alive on Oct 20 1917, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Mastoid

Pulmonary Embolism (?)

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Ruptured Cyst Ovary

..... (Duration) ... yrs. ... mos. 5 ds.

(Signed) H. H. Hamman M. D.

Oct 20, 1917. (Address) Church Home Inf

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 5 ds. In the State 26 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 123 Aisquith St. Balt.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Bd — DATE OF BURIAL, 10/21, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9387

CERTIFICATE OF DEATH.

43

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 E. Eager ST.; 11 WARD)

1If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Zoe Illoy.

(Residence in Baltimore: No. 224 E. Eager St.; St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 15, 1874 (Month) (Day) (Year)

7-AGE, 43 yrs. 5 mos. 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), France

PARENTS.

10-NAME OF FATHER, Pierre M. Zoe Claie

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Julia Dufreche

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Yves Zoe Illoy

(Address) 224 E. Eager St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 6, 1917, to October 19 1917; that I saw h alive on October 19 1917, and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma Right Breast

Metastasis

(Duration) yrs. 10 mos. 0 ds.

CONTRIBUTORY (Secondary) Metastasis to Mediastinal Glands (Duration) unknown yrs. mos. ds.

(Signed) Henry T. Collenberg M. D.

Oct. 20, 1917. (Address) 904 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 10/23, 1917

20-UNDERTAKER Henry W Mears & Son

ADDRESS 805 N. Gaines St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—5-19-13—M. & T.—500 Bks.

D 9388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 9388

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Hollins ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H Matilda Stephens

(Residence in Baltimore: No. 1325 Hollins St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Unknown (Month) 1837 (Day) (Year)

7-AGE, 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

8 0 0

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Thomas Hughes

(Address)..... 223 N F Pul St

15-

Filed..... OCT 21 1917 ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Oct 19 1917, that I saw her alive on Oct 19 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

General debility of age

(Duration) yrs 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Marshall G Wood M. D.

Oct 19, 1917 (Address) 11 E Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemy

DATE OF BURIAL, Oct 22, 1917

20-UNDERTAKER John O Mitchell

ADDRESS 1201 Fayette St

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9389

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Alice Anna St, ST.; X WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Chrzanowska

(Residence in Baltimore: No. 1713 Alice Anne St. St.; 52 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Single

6-DATE OF BIRTH, Unknow. (Month) (Day), 1855. (Year)

7-AGE,	If LESS than 1 day,
62 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Home work.
(b) General nature of industry, business, or establishment in which employed (or employer) at her home.

068

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, John Chrzanowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Kulita

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. A. Chrzanowski.

(Address) 1713 Alice Anna St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 19 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1917, to Oct. 19 1917, that I saw her alive on Oct. 19 1917, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Cerebral Hemorrhage)

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic renal disease

(Duration) 3 yrs. — mos. — ds.

(Signed) John H. Rehberger M. D.

Oct. 20, 1917. (Address) 1709 Alice Anne St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Oct. 22, 1917.
20-UNDERTAKER	ADDRESS
W. T. Sadowski.	705 Linn St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If under one year, state AGE in hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9390

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

80

D 9390

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3926 Park Heights Ave St. 5 WARD)

2-FULL NAME Martha J Pettit

(Residence in Baltimore: No 3926 Park Heights ave St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Mar. 27 (Month), 1841 (Year)

7-AGE: 76 yrs. 6 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Va

PARENTS

10-NAME OF FATHER: Robt Cooke

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Sarah Maisond

13-BIRTHPLACE OF MOTHER (State or country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hallie M. Pettit

(Address) 3926 Park Heights

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12, 1917, to Oct 19 1917, that I saw h.. alive on Oct 19 1917, and that death occurred, on the date stated above, at 1/2 9 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

4 Fen minutes (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Interstitial nephritis

(Duration) 1 yrs. mos. 7 ds.

(Signed) C. Van Williams M. D.

Oct 19, 1917 (Address) 201 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery | DATE OF BURIAL: Oct 22, 1917

20-UNDERTAKER: Robt D Turner | ADDRESS: 1442 N Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9391 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9391

CERTIFICATE OF DEATH.

REGISTERED NO. C 4001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 Glover ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann M Abell

(Residence in Baltimore: No. 1237 Glover St.; 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. January 6, 1844
(Month) (Day) (Year)

7-AGE. 73 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), St Marys Md

PARENTS.

10-NAME OF FATHER. Jos B Abell

11-BIRTHPLACE OF FATHER (State or Country) St Marys Md

12-MAIDEN NAME OF MOTHER. Anne Ann E Clark

13-BIRTHPLACE OF MOTHER (State or Country). St Marys Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie Dix

(Address) 1237 Glover St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1917, to Oct 20 1917, that I saw her alive on Oct 19th 1917, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Robert D Watt M. D.

Oct 20, 1917. (Address) 3126 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Spencer Chapel Md. DATE OF BURIAL, Oct 23, 1917

20-UNDERTAKER Robt E Sumner ADDRESS 1742 Pennsylvania Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9392

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2865 N Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Elizabeth B. Machen

(Residence in Baltimore: No. 2865 N Lanvale St.; Lightner yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Single

6-DATE OF BIRTH, October 20th (Month) (Day), 1872 (Year)

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael J. Machen

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. James B. Kahler

(Address) 901 Poplar Grove St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1 1917, to October 20th 1917, that I saw her alive on Oct 20th 1917, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) W. C. Grant M. D.

....., 191... (Address) 1207 Poplar Grove St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, 10-23 New Cathedral

DATE OF BURIAL, 10-23-..., 191...

20-UNDERTAKER H. C. Brauning & Son

ADDRESS 617 N Schroeder St

N. B.—Every item of information under the various headings should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 9393

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3rd Gen Hosp. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma V. Jones

(Residence in Baltimore: No. 307 N. Calhoun St.; 16 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... August (Month) 7 (Day), 1877 (Year)

7-AGE,	If LESS than 1 day,
40 yrs. 7 mos. 17 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School-teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 068

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, J. A. Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha E. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. Waters

(Address) 1921 N. Bolton St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 191 7, to Oct 19 191 7, that I saw h.. alive on Oct 19 191 7, and that death occurred, on the date stated above, at 12 15 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia-Chronic Nephritis

and Convulsions

(Duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 19, 191 7 (Address) 1921 N. Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State 40 yrs. 2 mos. 12 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 307 N. Calhoun St.

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct 21, 191 7

20-UNDERTAKER Joseph L. Cook — ADDRESS 1003 W. Balto St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 9391

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 E. Pratt ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmund A. A. Brüninge

(Residence in Baltimore: No. 2212 E Pratt St

St.; 23 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, November 25, 1856
(Month) (Day) (Year)

7-AGE, 60 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Chandler
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 886

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Carl Brüninge

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Badecker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Brüninge (wife)

(Address) 2212 E. Pratt St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 8th 1917, to October 19th 1917, that I saw h[illegible] alive on October 19th 1917, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Regurgitation

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) a cute Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) Thos F A Stearns M. D.

Oct 20, 191.., (Address) 2411 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Oct 22, 191.7.

20-UNDERTAKER H. E. Hughes — ADDRESS 17 S. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be filled EXACTLY. Physician may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 V

D 9395

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wallace

(Residence in Baltimore: No. 413 Lewis St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 5, 1915 (Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wallace

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Daisy Mathews

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

OCT 2 1917 ROBERT B. KRAUTER Registrar.
Social Pursuit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from October 5 1917, to Oct. 19 1917, that I saw h m alive on October 19 1917, and that death occurred, on the date stated above, at 6 10 p m.

The CAUSE OF DEATH* was as follows:

1. Tuberculosis Meningitis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Margaret T. Tyson M. D.

Oct 20, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 413 Lewis St

19-PLACE OF BURIAL OR REMOVAL, Evergreen

DATE OF BURIAL, Oct. 21, 1917

20-UNDERTAKER Wm. J. E. Locke

ADDRESS 1302 Jefferson

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-13—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9396

CERTIFICATE OF DEATH.

9 V D 9396

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. Catherine St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Zeinth Starlings

(Residence in Baltimore: No. 13 N. Catherine St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, Feby 18 1849 (Month) (Day) (Year)

7-AGE, 68 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Zeinth

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mar Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Weikert

(Address) 13 N Catherine St.

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 191 7, to Oct 21, 191 7,

that I saw h— alive on Oct 21 191 7

and that death occurred, on the date stated above, at 6.36 A m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. 1 ds.

(Signed) W. H. Hammerbacher M. D.

Oct 21, 191 7. (Address) 531 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Taylorsville Md — DATE OF BURIAL, Oct. 22, 191 7.

20-UNDERTAKER Geo. A. Gerbig — ADDRESS Balto & Payson St

ROBERT R. KRAUTER

OCT 22 1917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9397

CERTIFICATE OF DEATH.

92 D 9397

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perkins Hinton

(Residence in Baltimore: No. 530 Colvin St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, January 29, 1917
(Month) (Day) (Year)

7-AGE, ..yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sam Hinton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sadie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 15 191 7, to Oct 20 191 7, that I saw h alive on October 20 191 7, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute lobar

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Marquett Tyler M. D.

....., 191... (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 530 Colvin St

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery — DATE OF BURIAL, Oct. 22., 1917.

20-UNDERTAKER Dirk Robert A Elliott — ADDRESS 502 East St

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 22 1917 ROBERT B. KRUGTEN

Spec.—8-24-14—M. & T.—2000 Bks.

D 9393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

136 D 9393

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Davis

(Residence in Baltimore: No. 1845 N. Pfeiffer St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 20 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 037 .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jackson Dent

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 16 1917, to October 19 1917, that I saw her alive on October 19 1917, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
following Cesarean
Section

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) John Thomas Jr. M. D.

Octr 9 191 7. (Address) Johns Hopkins Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 ds. In the State all life yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1845 N Pfeiffer St

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct. 22 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1163 Henry

OCT 22 1917 ROBERT B. KRAUTER DEPUTY REGISTRAR

17 D 9399 Bessie E. Schribner D 9399

33 4

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1108 N Paca St.; 16 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie E. Schribner

(Residence in Baltimore: No. 1108 N. Paca St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 1 (Day), 1884 (Year)

7-AGE, (3) 33 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Husband

(Address) 1108 N Paca

15-

Filed OCT 22 1917, 191.... ROBERT E. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cold & Pneumonia

(Duration) yrs. mos. ds.

(Signed) T. J. Kelly M. D.
(Coroner.)

Oct. 21, 191... (Address) Park Circle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 22 1917

20-UNDERTAKER Edward Ringgold — ADDRESS 1163 N Gay

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9400 ✓ D 9400

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen. Hosp. ST.; 16 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary H. Beausfeld.

(Residence in Baltimore: No. 3126 Baker St St.; ....yrs.. ....mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 22nd (Month) (Day), 1857 (Year)

7-AGE, 59 yrs. 11 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Trenton N.J.

PARENTS.

10-NAME OF FATHER, Jos Kengel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary E Smith

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H Joo Beausfeld

(Address) 3126 Baker St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 20 191 7, to Oct 21 191 7, that I saw her alive on Oct 21 191 7, and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:

Multiple neuritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) 2 yrs. ....mos. ....ds.

(Signed) H. H. Hoffa M. D.

Oct 21, 191 7 (Address) Md. Gen. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 3126 Baker St.

19-PLACE OF BURIAL OR REMOVAL, Catoctin Co — DATE OF BURIAL, Oct 24th, 191 7

20-UNDERTAKER William Goff — ADDRESS 1123 N Calvert St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9401

CERTIFICATE OF DEATH.

42 D 9402

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 203 Scott St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Linton

(Residence in Baltimore: No. 203 Scott St. St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widow

6-DATE OF BIRTH, Aug 9th (Month) (Day), 1846 (Year)

7-AGE, 71 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country). Frederick Md.

PARENTS.

10-NAME OF FATHER. Jacob Goodman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER E. Wills

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Geo. E. Linton

(Address) 203 Scott St

15-

Filed....., 191.... Registrar.

OCT 22 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1917, to Oct 20 1917, that I saw h[illegible] alive on Oct 19 1917, and that death occurred, on the date stated above, at 5.15 p.m.

The CAUSE OF DEATH* was as follows:

a Carcinoma of Uterus

.....(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 20, 1917 (Address) 502 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Oct 22 1917
20-UNDERTAKER	ADDRESS
John J. Kearney & Son	908 Holliday St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Berry. ST.; Hampden 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda M. Furlong.

(Residence in Baltimore: No. 810 Berry st. St.; 1 yrs., 8 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Jan. 31, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Joseph L. Furlong.

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Ettie Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ettie Furlong.

(Address) 810 Berry St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16th 191?, to Oct 21 191?, that I saw h[illegible] alive on Oct 21 191?, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Pyroneho pneumonia

..... (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

..... (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 21, 1917, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Moriah Lawn | DATE OF BURIAL, Oct 23, 1917

20-UNDERTAKER Brownell & Son | ADDRESS 561 Chestnut

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 9103

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3333 Beech Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Sheffer

(Residence in Baltimore: No. 3333 Beech Ave St.; 28 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, January (Month) 15 (Day), 1844 (Year)

7-AGE, 73 yrs. 9 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balto Co. Md

PARENTS.

10-NAME OF FATHER, Peter Bailey

11-BIRTHPLACE OF FATHER (State or Country) Balto Co, Md

12-MAIDEN NAME OF MOTHER Sarah A. Lucabaugh

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alberta M. Sheffer

(Address) 3333 Beech Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 19th (Day), 1917 (Year).

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 19 1917, that I saw h[illegible] alive on Oct 19 1917, and that death occurred, on the date stated above, at 9-35 p.m.

The CAUSE OF DEATH* was as follows:

..... Mitral Insufficiency .....

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) 7 yrs. 11 mos. ..... ds.

(Signed) W. H. Fair M. D.

Oct 20 1917. (Address) 17 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. Md — DATE OF BURIAL, Oct 23, 191...

20-UNDERTAKER Unsworth & Son — ADDRESS 567 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9101

CERTIFICATE OF DEATH.

79 D 9101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1754 North Gay ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J Stark.

(Residence in Baltimore: No. 1754 North Gay St.; 60 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 7 (Day), 1838 (Year)

7-AGE, 79 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinetmaker
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 017

9-BIRTHPLACE, (State or Country), Europe (Germany)

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Stark

(Address) 1754 N. Gay

15— Filed....., 191.....

Registrar.

OCT 22 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1917, to Oct 21 1917, that I saw h[illegible] alive on Oct 20 1917, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

[illegible]

Mitral Stenosis probably

(Duration) ?3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 2 ds.

(Signed) Wm. R. Kraeuter M. D.

Oct 21, 1917 (Address) 1038 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct. 24, 1917

20-UNDERTAKER William Cook

ADDRESS 504 N. Oath

Spec.—8-24-14—M. & T.—2000 Bks.

D 9405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9405

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 n Bradford St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Lee Cullum

(Residence in Baltimore: No. 1730 n Bradford St.; 25 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, June (Month) 3 (Day) 1884 (Year)

7-AGE, 33 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): 073

9-BIRTHPLACE, (State or Country), Harford Co Md

PARENTS.

10-NAME OF FATHER, Chas Henry Cullum

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Baker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida M. Cullum

(Address) 1730 n Bradford St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 191 7, to Oct 21 191 7, that I saw him alive on Oct 20 191 7, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Phthisis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Patterson M. D.

Oct 21, 191 7 (Address) 1730 n Bradford St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem DATE OF BURIAL, Oct 23, 191...

20-UNDERTAKER W E Cook ADDRESS 532 E Balt St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 9406

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital Balto. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Ingram

(Residence in Baltimore: No. 719 E Franklin St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, June (Month) 22 (Day), 1892 (Year)

7-AGE,	If LESS than 1 day,
25 yrs. 3 mos. 30 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Annison Ingram

11-BIRTHPLACE OF FATHER (State or Country), Nomtenmration Va

12-MAIDEN NAME OF MOTHER Pattie Tiff

13-BIRTHPLACE OF MOTHER (State or Country), Columbian Grove Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hospital

(Address) C. Balto City

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Oct 21 1917, that I saw h Her alive on 21 Oct. 1917, and that death occurred, on the date stated above, at 7 55 m.

The CAUSE OF DEATH* was as follows:

Tubercalous Peritonitis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin H. Smith M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 24 ds. In the State....yrs. 18 mos....ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 719 E. Franklin St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Kenbridge Va	Oct 22 191 7
20-UNDERTAKER	ADDRESS
David Taylor	Duncan

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9407

CERTIFICATE OF DEATH.

56 D 9407

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth F. Stehr

(Residence in Baltimore: No. 1421 Holbrook St.; 58 yrs., 1 mos. 9 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October 11, 1859 (Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Peter Stehr

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Stepp

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Zeller

(Address) 1421 Holbrook St

15-

Filed....., 191.....

Registrar.

OCT 22 1917 FOREST P. KRAUTER BURIAL PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13th 1917, to Oct 20th 1917, that I saw her alive on Oct 20th 1917, and that death occurred, on the date stated above, at 9:55 a.m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(Duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. A. Stehr M. D.

Oct 22nd, 1917 (Address) 801 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Oct 23, 1917

20-UNDERTAKER Henry Horok Son

ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9103

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 9103

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S. Milton ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Miller

(Residence in Baltimore: No. 604 S. Milton Ave St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Aug. 12th, 1899. (Month) (Day) (Year)

7-AGE. 18 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sewing Machine
(b) General nature of industry, business, or establishment in which employed (or employer): Operator 069

9-BIRTHPLACE, (State or Country): Baltimore City Md.

PARENTS.

10-NAME OF FATHER: John C. Miller

11-BIRTHPLACE OF FATHER (State or Country): Baltimore City Md.

12-MAIDEN NAME OF MOTHER: Catherine Bauer

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore City Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Miller

(Address) 604 S. Milton Ave.

15-

OCT 22 1917 ROBERT E. KRAUTER REGISTRAR OF VITAL STATISTICS

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 19th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1917, to Oct 19th 1917, that I saw her alive on Oct 16th 1917, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ....yrs. 10 mos. ....ds.

(Signed) H. L. Edmund M. D.

Oct 19th, 191.7 (Address) 610 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Oct. 23., 191.7.

20-UNDERTAKER A. Snyder & Son ADDRESS 111 Mosher St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9409

CERTIFICATE OF DEATH.

1920 D 9409

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Jane Whitaker

(Residence in Baltimore: No. 206 S. Stricker St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Married

6-DATE OF BIRTH, 2 (Month) 21 (Day), 1878 (Year)

7-AGE, 39 yrs. 8 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Hanover Pa

PARENTS.

10-NAME OF FATHER, Wm Drecher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Glouser

13-BIRTHPLACE OF MOTHER (State or Country), Switzerland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml W Whitaker

(Address) 206 S Stricker St

15-

Filed ....., 191.... Registrar.

OCT 22 1917 ROBERT B. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 20 1917, that I saw h[illegible] alive on Oct 20 1917, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) X yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) X yrs. X mos. 5 ds.

(Signed) P Blackburn M. D.

10/20, 1917 (Address) 1939 Wilkens Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hanover Pa	Oct 23, 1917
20-UNDERTAKER Robert Brickson	Glouser Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9210

CERTIFICATE OF DEATH.

28 ✓ D 9210

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Burley ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna S Spicer

(Residence in Baltimore: No. 506 N Burley St.; 37 yrs., 9 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan (Month) 9 (Day), 1880 (Year)

7-AGE, 37 yrs. 9 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Md City

PARENTS.

10-NAME OF FATHER, Joseph H. Jones

11-BIRTHPLACE OF FATHER (State or Country), Md City

12-MAIDEN NAME OF MOTHER Anna Keeder

13-BIRTHPLACE OF MOTHER (State or Country), Md City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John S Spicer

(Address) 506 N. Burley St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21 (Month) (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 21 1917, that I saw h[illegible] alive on Oct 20 1917, and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

(a) Phthisis Pulmonalis

(b)

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emil Novak M. D.

Oct 22, 1917. (Address) 16 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Edmondson Ave Cem — DATE OF BURIAL, Oct 23, 1917.

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2046 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 9111

1-PLACE OF DEATH 4ward REGISTERED NO. C

CITY OF BALTIMORE: (No. 1328 Pennsylvania St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E. Heinmiller

(Residence in Baltimore: No. 1328 Pennsylvania ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 25, 1840
(Month) (Day) (Year)

7-AGE, 77 yrs. 1 mos. 25 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Heinmiller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine E. Zulauf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. M. Heinmiller

(Address) 1328 Pennsylvania ave

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 21st, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 17 1917, to Oct. 21 1917, that I saw h-er alive on Oct. 7 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis -

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. 414 N. Greene St. M. D.

Oct. 21st 1917. (Address) Louis W. Knight M.D

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine | DATE OF BURIAL, Oct. 24, 1917.

20-UNDERTAKER Pikler & Pikler | ADDRESS 1739 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9112

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 9112

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Robinson St. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Bertha Noland

(Residence in Baltimore: No. 2823 S Robinson St.; 1 yrs., 1 mos. 8 ds.)

WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Sept (Month) 11 (Day), 1916 (Year)

7-AGE: 1 yrs. 1 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Clarence B Noland

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary P Phillips

13-BIRTHPLACE OF MOTHER (State or Country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Noland

(Address) 2823 S Robinson St

15-

Filed....., 191....

Registrar.

OCT 22 1917 ROBERT R. [illegible] Assistant Deputy Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 19 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Oct 19 1917, that I saw her alive on Oct 19 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Cerebro Meningitis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Epilepsy Convulsions

(Duration) ....yrs. ....mos. 7 ds.

(Signed) M McSherry M. D.

Oct 20, 1917. (Address) 330 W Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: Oct 22, 1917

20-UNDERTAKER: John Herring & Co — ADDRESS: 2005 Eutaw

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9113

1 PLACE OF DEATH

120 ✓ D 9113

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1919 St. Paul St.: 12 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Glennead,

(Residence in Baltimore: No. 1919 St. Paul St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: June (Month) 27 (Day), 1857 (Year)

7 AGE: 60 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION: 045 ✓

(a) Trade, profession, or particular kind of work: Malt mnfg.

(b) General nature of industry, business, or establishment in which employed (or employer): Retired since 1904

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Francis Glennead,

11 BIRTHPLACE OF FATHER (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Roselie V. Labby

13 BIRTHPLACE OF MOTHER (State or country): Virginia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Glennead Jr.

(Address) 1914 N Gilmor.

15.

OCT 22 1917

Filed ....., 191.... ROBERT R. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 20 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1917. to. Oct. 20 1917. that I saw him alive on Oct. 20. 1917. and that death occurred. on the date stated above. at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Chronic interstitial nephritis

(Duration) 1+ yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ronald T. Abercrombie M. D.

Oct 20. 1917 (Address) 18 W. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Oct 23rd, 1917

20-UNDERTAKER: Henry T. Jenkins Sons & Co. ADDRESS: McCulloh & Eutaw St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Lillian M. Bayne

(D) 9117

HEALTH DEPARTMENT—CITY OF BALTIMORE

156

D 9117

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 503 N Ellwood St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian May Bayne

(Residence in Baltimore: No. 503 N Ellwood St.; yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Mar

6-DATE OF BIRTH, Sept 28, 92 (Month) (Day) (Year)

7-AGE, 24 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Home 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm Weir

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Elleanor Bayne

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl E Bayne

(Address) 503 N Ellwood

15-

Filed....., 191.... Registrar.

ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Fowler M. D.
(Coroner)

Oct 19, 1917 (Address) 711 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 503 N Ellwood

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 10-22, 1917

20-UNDERTAKER Howard E Sulley — ADDRESS 2713 Edmondson

D 9115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9115

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital 10 ST. 186 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perry Terry

(Residence in Baltimore: No. 807 Sapp St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... (Month) [redacted], ... (Day) 1 ..... (Year)

7-AGE, 24 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

3 24

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, James Terry

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nancy White

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Terry Wife

(Address) 807 Sapp St

15-

OCT 22 1917 ROBERT B. KRAUTER

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct. (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Shock caused by severe burns

..... to abdomen, upper back,

..... & abdominal structures. Duration ..... yrs. ..... mos. ..... ds.

Dy Burns and Shock yrs.

CONTRIBUTORY (Secondary) Shock after

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley M. D.

(Coroner.)

Oct 22, 1917. (Address) 1825 Bus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Albery Cemetery

DATE OF BURIAL, Oct 22, 1917

20-UNDERTAKER R. E. Gross

ADDRESS 1406 McElderry St

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9116

120 D 9116

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Ashland Ave St.; 10 WARD)

2-FULL NAME Samuel Gray

(Residence in Baltimore: No. 920 Ashland Ave St.; 15 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Don't know ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Zaricka Gray

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Mary E Badison

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James G Gray

(Address) 1629 Aisquith St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct ..... (Month) 21 ..... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 21 1917, that I saw him alive on Oct 21 1917, and that death occurred, on the date stated above, at 4460 P m.

The CAUSE OF DEATH* was as follows:

..... Asthma Dropsy .....

..... Heart .....

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Kidneys Hard .....

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) D G W Kennard M. D.

Oct ....., 1917. (Address) 708 Esson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bothers Calvert Co

DATE OF BURIAL, Oct 24, 1917.

20-UNDERTAKER Wm. Cook

ADDRESS 1722 E Monument

D 9117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9117

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1709 S.Charles St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E.Rhea.

(Residence in Baltimore: No. 1709 S.Charles St St.: 35 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married.

6-DATE OF BIRTH, November 28th. 1847. (Month) (Day) (Year)

7-AGE, 69 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer in 040
(b) General nature of industry, business, or establishment in which employed (or employer) Enameling works.

9-BIRTHPLACE, (State or Country). Dorchester Co,Md.

PARENTS.

10-NAME OF FATHER, William Rhea.

11-BIRTHPLACE OF FATHER (State or Country) Scotland.

12-MAIDEN NAME OF MOTHER Elizabeth Seward.

13-BIRTHPLACE OF MOTHER (State or Country) Dorchester Co,Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah M.Rhea.(wife)

(Address) 1709 S.Charles St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19th. 1917. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Otto M.Reinhardt M. D.

Oct.20,1917. (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Oct 23, 1917

20-UNDERTAKER Mrs J. E. Ennis & Son ADDRESS 1428 E Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9118

D 9118

40

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 E Church St.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice G Weber

(Residence in Baltimore: No. 120 E Church St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...Jan....25...., 1860
(Month) (Day) (Year)

7-AGE, 57 yrs. 8 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Horse
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Meibs

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Minnie Meibs

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip D Weber

(Address) 120 E Church St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1917
Aug 15 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 191 7, to Oct 21 191 7, that I saw h alive on Oct 20 191 7, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

.....Dy.....
.....Chronic.....
.....Myocarditis.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration).....yrs.....mos.....ds.

(Signed) M. F. Campbell M. D.

Oct 22, 191 7 (Address) 1624 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westernbentag

DATE OF BURIAL, Oct 23, 191 7

20-UNDERTAKER M. F. Evans & Son

ADDRESS 1428 Charles St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, of OCCUPATION is very important. See instructions on back.

D 9419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9419

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ..... St.: 3 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. 241 S. Dallas St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	

6-DATE OF BIRTH, Unknown (Month), (Day) 1 (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JOHNS

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, about October 1st, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Wedgett (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Ryan Wedgett, M. D.
(Coroner)

Oct 4, 191 7 (Address) 1501 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	OCT 22 1917, 19....
20-UNDERTAKER	ADDRESS
Commissioner Health.	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9420

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

42 D 9420

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 747 N. Crass St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Black.

(Residence in Baltimore: No. 747 N. Crass St. 63 yrs. \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH Mar. 18, 1839 (Month) (Day) (Year)

7 AGE 78 yrs. 7 mos. 2 ds. If LESS than 1 day, \ hrs. or \ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Muth

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eleanora Black

(Address) 747 N. Crass St

15.

Filed ..... 191 .....

REGISTRAR

OCT 22 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 20, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1917, to Oct. 20 1917.

that I saw h[illegible] alive on Oct. 19, 1917.

and that death occurred, on the date stated above, at 8A, m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) \ yrs. \ mos. 3 ds

Contributory (SECONDARY) Dilatation of Heart

(Duration) [illegible] yrs. mos. ds.

(Signed) Albert L. Chambers M. D.

Oct. 20, 1917 (Address) 1012 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park — DATE OF BURIAL Oct. 23rd, 191[illegible]

20 UNDERTAKER Wm. H. Jewell — ADDRESS 601 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9121

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1817 Boul ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Baker

(Residence in Baltimore: No. 2038 E Brook St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 7, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 13 mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John E Baker

11-BIRTHPLACE OF FATHER. (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Woodard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Baker

(Address) 2038 E Brook (24)

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Medicate (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions (Infantile)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Enteritis

(Duration) yrs. mos. ds.

(Signed) Henry Paul Dutton M. D.
(Coroner.)

Oct 20, 1917 (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus Bpmt.	Oct. 22, 1917
20-UNDERTAKER John A. Moran	ADDRESS 2000 E Baltimore St.

OCT 22 1917 REGISTRAR B. STARKEY

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9122

D 9122

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Montford ave. St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Pindle

(Residence in Baltimore: No. 222 Montford ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Married

6-DATE OF BIRTH, ... (Month) Unknown (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
79 yrs. ....mos. ....ds.	....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elisha Pindle

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maria Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Pindle

(Address) 222 Montford ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1917, to Oct. 19 1917, that I saw h[illegible] alive on Oct. 19, 1917, and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

..... (Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Senile Debility

..... (Duration) ?....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) 1520 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cemetery	Oct. 23rd, 1917.
20-UNDERTAKER Theodore White	ADDRESS 113 S. Wolfe St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9123

CERTIFICATE OF DEATH.

91 D 9123

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Fissuit ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard E Stanton

(Residence in Baltimore: No. 1917 Fissquitt St.: 2 yrs. 8 mos. 18 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	colored	Single

6-DATE OF BIRTH, Feb (Month) 2 (Day), 1915 (Year)

7-AGE, 2 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Stanton

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Cecelia Logan

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs E Stanton Mother

(Address)..... 1917 Fissuit

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1917 (Year) OCT 20 1917

17- I HEREBY CERTIFY, That I attended deceased from OCT 18 1917 191.., to OCT 20 1917 191..., that I saw h.. alive on OCT 20 1917 191..., and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Dunker M. D.

OCT 22 1917, 191.. (Address) 928 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cmtry	Oct 23, 191.7
20-UNDERTAKER Grot Holland	ADDRESS 671 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9421 ✓ D 9421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor 79 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gallagher

(Residence in Baltimore: No. Little Sisters of the Poor St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. ..... October ....., 1850
(Month) (Day) (Year)

7-AGE. 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Hugh Smith

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Mary Brown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.... Registrar.

OCT 22 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No record 191 , to 191 ,

that I saw her alive on Oct 14 191 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Disease of Heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. mos. ds.

(Signed) M. D.

Oct 21, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Peters DATE OF BURIAL. Oct 23, 191 7

20-UNDERTAKER M Foley & Sons ADDRESS 406 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9425

D 9425

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Keenan

(Residence in Baltimore: No. 519 W Lombard St St.; unknown yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Married

6-DATE OF BIRTH, unknown ....., 18.16
(Month) (Day) (Year)

7-AGE, 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cooper
(b) General nature of industry, business, or establishment in which employed (or employer) 021

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, D. F. Keenan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Nora Kirby

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Keenan

(Address) 2008 E. Main St. Richmond Va.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct 21 1917, that I saw h alive on Oct 21 1917, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Aorta

Aneurism of Aorta

(Duration) ..... yrs. unknown mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 21, 1917. (Address) ..... Hospl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State unknown yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 519 W. Lombard St

19-PLACE OF BURIAL OR REMOVAL, Richmond Va

DATE OF BURIAL, ..., 191...

20-UNDERTAKER W. J. Tuckner & Son

ADDRESS North 9th Pace Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9426

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wordsworth Wilson Wiltshire

(Residence in Baltimore: No. 2227 Hudson St.; ..... yrs. 7 mos. 17 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 5 (Day), 1917 (Year)

7-AGE, ... yrs. 7 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Christian Wiltshire

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ida Jennings

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Wiltshire

(Address) 2227 Hudson St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22nd (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th 191 7, to Oct 22nd 191 7, that I saw him alive on Oct 18th 191 7, and that death occurred, on the date stated above, at 6.25 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Schwatka M. D.

Oct 22nd, 191 7. (Address) 734 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

at Evangelical Cemetery ....., 191.

20-UNDERTAKER ADDRESS

Christian Miller 2334 Hoffman

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9427

CERTIFICATE OF DEATH.

92 D 9427

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Belnord Ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ely Cox

(Residence in Baltimore: No. 121 N. Belnord ave St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, September 4 1859
(Month) (Day) (Year)

7-AGE. 58 yrs. 1 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired 087
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Sailor

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ely T. Cox

(Address) 121 N. Glover st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21/17 191...
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 21 1917, that I saw h.. alive on Oct 21 1917. and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Meyer M.D.

Oct 21, 1917. (Address) 1638 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Crisfield Md

DATE OF BURIAL, Oct 22, 191...

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 9428

28 D 9428

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2253 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer C. Schettle

(Residence in Baltimore: No. 2253 Mc Elderry St.; 34 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 4 (Day), 1883 (Year)

7-AGE, 34 yrs. 4 mos. 16 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Horse Shoer
(b) General nature of industry, business, or establishment in which employed (or employer): 036

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Christopher Schettle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Schettel

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Schettle

(Address) 2253 Mc Elderry st.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 20 1917, that I saw him alive on Oct 20 1917 and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) J. L. Rey M. D.

Oct 20, 1917 (Address) 607 N. Patterson Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Oct. 23, 1917

20-UNDERTAKER Christian Foltz

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9429

CERTIFICATE OF DEATH.

28 D 9429

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Lakewood Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lochel

(Residence in Baltimore: No. 819 N. Lakewood Ave St.; 55 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, August 13 (Month) (Day), 1856 (Year)

7-AGE, 61 yrs. 2 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Hat + Shoe Merchant

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Lochel

(Address) 819 N. Lakewood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1916, to Oct 20 1917, that I saw h... alive on Oct 20 1917, and that death occurred, on the date stated above, at 1 8 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

3

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. Donnelan M. D.

Oct 20, 191... (Address) 7 W Fredon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Oct 23, 1917
20-UNDERTAKER	ADDRESS
Christian Miller	2384 Eastern Ave

D 9430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9430

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2641 Hoper St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hergenhahn

(Residence in Baltimore: No. 2641 Hoper St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	M

6-DATE OF BIRTH, Oct (Month) 21 (Day), 1917 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 2 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harry Hergenhahn

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Pifer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Hergenhahn

(Address) 2641 Hoper St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paramon Dvals of heart

Insufficiency

(Duration) .....yrs. .....mos. 1/2 ds.

CONTRIBUTORY (Secondary) Congenital

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M Fenton M. D.
(Coroner.)

Oct 22 1917 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct 22, 1917
20-UNDERTAKER	ADDRESS
F. P. Kuppuch	1786 Fred'k Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

OCT 22 1917 HARRY C. ANDREWS Burial Permit

D 9431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9431

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 117 W. York St. St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Earley.(C)

(Residence in Baltimore: No. 117 W. York St. St.; yrs. 20 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	Colored	Single.

6-DATE OF BIRTH, ... Do not know. (Month), / (Day), ... (Year)

7-AGE, ... 50 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 243 040

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country) Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Allen.(C)

(Address) 117 W. York St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 18th. 1917. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

Duration.....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

Oct. 22, 1917. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 23 1917

20-UNDERTAKER	ADDRESS
J. L. Brown	1005 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9432

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9432

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 442 E Fort Ave St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas C. Montgomery

(Residence in Baltimore: No. 442 E Fort Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July (Month) 4th (Day), 1862 (Year)

7-AGE: 55 yrs. 3 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Mariner
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: Tyson Montgomery

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Elizabeth Morey

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Selina Montgomery

(Address) 442 E Fort Ave

15

OCT 22 1917

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 21st (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17th, 1917, to Oct 21st 1917, that I saw h~~im~~ alive on Oct 21st, 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

History 9 days (Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B Kolb M. D.

Oct 22, 1917 (Address) 1203 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Dellwood Middlesex Co. Va

DATE OF BURIAL: Oct 23, 1917

20-UNDERTAKER: Armstrong Denny Co

ADDRESS: 715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9433

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

54 D 9433

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1518 Fraction St.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Doll

(Residence in Baltimore: No. 1518 Fraction St.: 23 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Unknown (Month) , 1 (Day) (Year)

7 AGE: 37 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Home Keeper 033 070

(b) General nature of industry, business, or establishment in which employed (or employer): in Private family

9 BIRTHPLACE (State or country): Austria

PARENTS

10 NAME OF FATHER: Vale Doll

11 BIRTHPLACE OF FATHER (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Steve Doll

(Address) Washington D. C.

15.

Filed OCT 2 1917, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 21 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 , 191 7 , to Oct 21 1917 .

that I saw her alive on Oct 20 1917 .

and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Cardiac Asthenia

(Duration) — yrs. mos. 1 ds.

(Signed) Edwin Mitchell M. D.

Oct 22 1917 (Address) 2112 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park | DATE OF BURIAL: Oct 25 , 191 7

20 UNDERTAKER: M. E. Flynn | ADDRESS: 1422 Light St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9431

CERTIFICATE OF DEATH.

115 D 9431

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter ostrowski.

(Residence in Baltimore: No. Clayton, Harford Co. Md. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month), 1 (Day) (Year)

7-AGE. 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER. dont know

11-BIRTHPLACE OF FATHER (State or Country). dont Know

12-MAIDEN NAME OF MOTHER. dont know

13-BIRTHPLACE OF MOTHER (State or Country). dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. J. Simms

(Address) 9182 Broadway

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October (Month) 20 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1917, to Oct. 20, 1917, that I saw him alive on Oct. 20, 1917, and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Ulcerative Colitis

Abscess of liver

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 3 ds.

(Signed) J. Edw. Simms M. D.

10/20/, 191.7. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death? at residence

Former or usual residence Clayton, Harford Co. Md.

19-PLACE OF BURIAL OR REMOVAL. Bradshaw, Md.

DATE OF BURIAL. Oct 23, 191.7

20-UNDERTAKER John P. Crowe

ADDRESS 307 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9435

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Wayne St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Callahan

(Residence in Baltimore: No. 618 Wayne St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, August (Month) 9 (Day) 1861 (Year)

7-AGE, 36 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boot Black
(b) General nature of industry, business, or establishment in which employed (or employer): Camden and Howard

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Mackeby Callahan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lottie —

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Callahan

(Address) 618 Wayne St

15-

OCT 23 1917 ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Oct 20 1917, that I saw h— alive on Oct 20 1917, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows: Pneumonia (Lob.)

(Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. 1 mos. 7 ds.

(Signed) C. B. Flaxa M. D.

Oct 22 1917 (Address) 914 S. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn C	Oct 23, 1917
20-UNDERTAKER C. E. Brown & Son	ADDRESS 118 Mulberry

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 9436

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 N. North Ave ST.; 13 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Cogill

(Residence in Baltimore: No. 932 N. North Ave St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec (Month) 31 (Day), 1851 (Year)

7-AGE, 65 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Harry R. Hueland

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia Pa

12-MAIDEN NAME OF MOTHER Margaret D Morgan

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John B Morgan

(Address) 932 N. North Ave

15-

Filed ....., 191.....

OCT 23 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 12 1915, to Oct 21 1917, that I saw her alive on Oct. 21 1917, and that death occurred, on the date stated above, at 10 1/2 a.m.

The CAUSE OF DEATH* was as follows: Diabetes complicated Organic disease of heart

(Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Heart Pulm Cystitis

(Duration) yrs. mos. 2 ds.

(Signed) L. E. Hurd M. D.

Oct 21, 1917 (Address) 1627 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 23, 191.

20-UNDERTAKER Jo Block ADDRESS 1003 W Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9437

CERTIFICATE OF DEATH.

151 D 9437

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 E. Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Flaxenbaum

(Residence in Baltimore: No 909 E. Lombard St.; ....yrs., ...mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Infant

6-DATE OF BIRTH, Oct. (Month) 21 (Day), 1917 (Year)

7-AGE, ...yrs....mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Balto. md.

PARENTS.

10-NAME OF FATHER, Max Flaxenbaum

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fanny Falkowan

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Faxenbaum

(Address) 909 E. Lombard

15-

OCT 23 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 191 7, to Oct 22 191 7, that I saw h.. alive on Oct 22 191 7, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

(a) Premature birth, fetus 7 months gestation

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) D. G. M. edelbaum M. D.

Oct 22, 191 7. (Address) 1420 E. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt. Carmel Woodmansburg | DATE OF BURIAL, Oct 24, 191 7

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E. Balto.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9138

HEALTH DEPARTMENT—CITY OF BALTIMORE

+45 D 9138

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert G. Callum

(Residence in Baltimore: No. 1729 De Sales St Wash D. C St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, January, 1855
(Month) (Day) (Year)

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): 029

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, J R Callum

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER M Clavey

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Data

(Address) Greenmount

15-

Filed....., 191.....

Registrar.

OCT 23 1917 ROBERT R. KRAUTER Chief Bureau Records

over

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1917, to Oct 22 1917, that I saw h[illegible] alive on Oct 22 1917, and that death occurred, on the date stated above, at 3p m.

The CAUSE OF DEATH* was as follows:

Surgical Shock following supra pubic prostatectomy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(Duration) 2 yrs. mos. ds.

(Signed) C A Reifschneider M. D.

10/22, 191 7 (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 0 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Washington D C

19-PLACE OF BURIAL OR REMOVAL, Washington D. C — DATE OF BURIAL, 10-23, 191 7

20-UNDERTAKER Henry W. Jenkins Sons — ADDRESS Edward & McCulloh Sts

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9139

CERTIFICATE OF DEATH.

120 D 9139

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 727 Franklin W ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Laurence

(Residence in Baltimore: No. 727 Franklin W St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 14, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country) St Marys Co Md

PARENTS.

10-NAME OF FATHER, Edward Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Carter

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence E Smith

(Address) Relay Md

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 21 1917, that I saw her alive on Oct 21 1917, and that death occurred, on the date stated above, at 7 1/2 a m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Dropsy Uremia

(Duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Street Fracture

(Duration) yrs. 6 mos. 4 ds.

(Signed) L R Gill Brumbaugh M. D.

Oct 21, 1917. (Address) 708 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence St Marys Co Md

19-PLACE OF BURIAL OR REMOVAL, Milestone Cemetery

DATE OF BURIAL, Oct 24 17, 191.

20-UNDERTAKER Clarence E Wolfe

ADDRESS 1364 Mary

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9440

CERTIFICATE OF DEATH.

91 D 9440

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1547 Argyle Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John I Smallwood

(Residence in Baltimore: No. 1547 Argyle ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, July (Month) ..... (Day) 1864 (Year)

7-AGE, 53 yrs. 3 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor 086
(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Smallwood

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emlie Curtis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Smallwood

(Address) 1547 Argyle ave

15-

Filed....., 191.....

Registrar.

OCT 23 1917 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23d (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17th 1917, to Oct 22nd 1917, that I saw h m alive on Oct 22nd 1917, and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 23, 1917. (Address) 609 N Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 28, 1917

20-UNDERTAKER, Lawrence O'Neill

ADDRESS 364 W Fayette

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9111

CERTIFICATE OF DEATH.

79 D 9111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 N Calvert ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F Peace

(Residence in Baltimore: No. 2112 N Calvert St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov (Month) 10 (Day), 1849 (Year)

7-AGE, 67 yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk Court
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, George Peace

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Peace

(Address) 2112 N. Calvert St.

15-

OCT 23 1917 ROBERT R. KRAUTER

Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 22 1917, that I saw him alive on Oct 21 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Indigest

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph D. Herring M. D.

Oct 23, 1917. (Address) 1812 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, Oct. 24., 1917.

20-UNDERTAKER John D Mitchell

ADDRESS 1201 W Fayette St

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9442

28 D 9442

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Luther Place St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Burns

(Residence in Baltimore: No. 1412 Kepler Place St.; 35 yrs. ... mos. ... ds.)

WRITE PLAINLY, with UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: June (Month) 30th (Day), 1852 (Year)

7-AGE: 65 yrs. 3 mos. 27 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Strauss Bros.

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Samuel Strauss

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Strauss

(Address) 1412 Kepler Place

15-

Filed ..... 191.....

OCT 23 1917 ROBERT B. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 22 - (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 -, 191 7, to Oct 22 191 7, that I saw h[illegible] alive on Oct 15 191 7, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs 5 mos. ... ds.

Contributory (SECONDARY) Exhaustion

(Duration) ... yrs. ... mos. 1 ds.

(Signed) Geo. B. Ladew M. D.

10/22/17 191.... [Address] 140 N Bway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: 10-24, 1917

20-UNDERTAKER: John J. Fields

ADDRESS: 1200 W Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

D 9413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 9413

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Smyth

(Residence in Baltimore: No. 1538 Orleans St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October 21, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 1 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Estelle Smyth

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle Smyth

(Address) 1538 Orleans St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 21 1917, that I saw h[illegible] alive on Oct 21 1917, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

3 month Premature Birth

Birth Constitution

.....(Duration).....yrs.....mos.....1.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) Edward Lee K M. D.

Oct 21, 1917. (Address) 413 N. Washington.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Johns Hopkins Mutual Phon[illegible] DATE OF BURIAL, 10/22, 1917.

20-UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9117

CERTIFICATE OF DEATH.

45

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Harford Ave. St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benedikt Kavanaugh

(Residence in Baltimore: No. 1100 Harford Ave St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 14 (Day), 1863 (Year)

7-AGE, 54 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dealer in
(b) General nature of industry, business, or establishment in which employed (or employer): Bones & Tallows

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dennis Kavanaugh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Conroy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Kavanaugh

(Address) 1100 Harford Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1917, to Oct 21 1917, that I saw h— alive on Oct 21 1917, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Cadeno carcinoma of Cervical Glands & Middle Ear

(Duration) 4 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Septic Intoxication

(Duration) yrs. 1 mos. ds.

(Signed) James M Fenlon M. D.

Oct 23 191.. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Oct 23, 191..

20-UNDERTAKER H. C. Woodfield

ADDRESS 914 Gramont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9115

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Hollman St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Patterson

(Residence in Baltimore: No. 1018 Hollman St.; 1 yrs., 8 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH: March 17, 17
(Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Benj Patterson

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Minnie Cordell

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Patterson

(Address) 1018 Hollman St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 21 1917, to Oct 22 1917, that I saw h[illegible] alive on Oct 21 1917, and that death occurred, on the date stated above, at 8-10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D Peck M. D.

Oct 22, 191.. (Address) 1365 Myrtle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore — DATE OF BURIAL, Oct 23, 191..

20-UNDERTAKER H C Weedfield — ADDRESS 814 Fremont Ave

OCT 23 1917 ROBERT B. KRAUTER Burial Permit

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9446

CERTIFICATE OF DEATH.

D 9446

REGISTERED NO. C .....

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Slattery

(Residence in Baltimore: No. Little Sisters of the Poor St.; 70 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct. 10, 1847
(Month) (Day) (Year)

7-AGE, 69 yrs. 0 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

8-00 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

OCT 23 1917 ROBERT B. KRAUTER

Filed ....., 191.. .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22nd 191.., to ..... 191..,
that I saw her alive on Oct 14 191.., and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as followa:

(a) Arteriosclerosis
(b) .....
(c) .....
Influenza (Duration) 1 wk yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Disease 16 years
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Oct 22, 191.. (Address) 1133 Valley st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 8 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Oct. 24, 191..

20-UNDERTAKER J. C. Wiedefeld

ADDRESS 9-11 Dumonmtion

Spec.—8-24-14—M. & T.—2000 Bks.

D 9147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 9147

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Stewart ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace D. Davis

(Residence in Baltimore: No. 1005 Stewart St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov (Month) 29 (Day), 1916 (Year)

7-AGE, ...yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James K Davis

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Charlotte Moon

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Davis

(Address) 1005 Sumit st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Oct 21 1917, that I saw h-r alive on Oct 20 1917, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Antepartum Labor

(Duration) ....yrs. 1 mos. ....ds.

(Signed) John S. Fenby M. D.

10/22, 1917. (Address) 1734 Cornelius Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Cedar Hill Cemetery

DATE OF BURIAL. Oct. 23, 1917

20-UNDERTAKER James Pegram & Son

ADDRESS 1000 E. Preston

OCT 23 1917 ROBERT B. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9448

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 9448

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 Lemmon ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Elliott

(Residence in Baltimore: No. 834 Lemmon St

St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, ... June ....., 1 .....
(Month) (Day) (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Elliott

(Address) 834 Lemmon St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 191 7, to Oct 21 191 7, that I saw h alive on Oct 21 191 7, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 24, 1917

20-UNDERTAKER Charles B Jones

ADDRESS 506 Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9149

CERTIFICATE OF DEATH.

37 D 9149

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Elsie Harper

(Residence in Baltimore: No. 1331 Argyle Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, 26 yrs past Aug. 26 (Month) (Day), 1891 (Year)

7-AGE, 26 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. chambermaid (b) General nature of industry, business, or establishment in which employed (or employer). on boat

9-BIRTHPLACE, (State or Country) Prince Geo Co Maryland

PARENTS.

10-NAME OF FATHER, H. A. Mayruder

11-BIRTHPLACE OF FATHER (State or Country), Prince Georges Co Md

12-MAIDEN NAME OF MOTHER Prince Georges Co Md

13-BIRTHPLACE OF MOTHER (State or Country), Mary Klasci.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie Harper

(Address) 1331 Argyle Ave

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1917, to Oct. 21, 1917, that I saw h e alive on 10/20/17 191, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia } Nephritis acute.

} Coma

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac anemia

(Duration) — yrs. — mos. 1 ds.

(Signed) J. Edw. Towns M. D.

10 | 21 | 17 (Address) St. Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. 1 ds. In the State life yrs. mos. ds.

Where was disease contracted, if not at place of death? at home.

Former or usual residence 1331 argyle ave.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery DATE OF BURIAL, Oct 23, 191.

20-UNDERTAKER Felix R. Fitz ADDRESS 1125 Edmondson Ave

OCT 23 1917 THOMAS B. KRAUTER

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9150

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 S. Charles ST.; 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanora M. Bartlett

(Residence in Baltimore: No. 1826 S. Charles St.; 50 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, September 17, 1864
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
53 yrs. 1 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John G. Hause

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie M. Carter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy Bartlett

(Address) 1826 S. Charles St

15-

Filed....., 191.....

Registrar.

OCT 23 1917 ROBERT B. KRAUTER Special Form

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Oct 21 1917, that I saw h.r alive on Oct 21 1917, and that death occurred, on the date stated above, at 7-40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ulcer Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) R. L. Campbell M. D.

Oct 22 1917 (Address) 1644 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. ✓ ds. In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence ✓

19-PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL.
Mt. Olivet Cemetery	Oct 24, 1917
20-UNDERTAKER	**ADDRESS**
Stuart Memorial Co	108 N. Howard

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Eastern Ave St. 22 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. McEord.

(Residence in Baltimore: No. 2016 Eastern Ave St.; 59 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 20th, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. 11 mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Produce Dealer
(h) General nature of industry, business, or establishment in which employed (or employer)..... 645

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thos. H. McEord.

11-BIRTHPLACE OF FATHER (State or Country), U. S.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar McEord

(Address) 2016 Eastern Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1917, to Oct 20 1917, that I saw him alive on Oct. 18 191, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

(Signed) Chas Green M. D.

10/24/17, 191... (Address) Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Oct. 23rd, 1917.

20-UNDERTAKER Lilly & Zeller

ADDRESS 403 S. Mo[illegible]

OCT 23 1917 ROBERT R. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9152

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 9152

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. Ann ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Riedelmann

(Residence in Baltimore: No. 812 S. Ann St.; 10 yrs., 6 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 14th, 1849 (Month) (Day) (Year)

7-AGE, 68 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Factory 417

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Riedelmann

(Address) 812 S. Ann St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21st, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21st 191 7, to Oct 21st 191 7, that I saw h[im] alive on Oct 21st 191 7, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis, Influenza.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Fiss M. D.

Oct 22nd, 191 7. (Address) 74 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct 24, 1917

20-UNDERTAKER Lilly & Zeeler ADDRESS 408 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9153

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 9153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd Generous St. 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Blackman

(Residence in Baltimore: No. 734 W. Mulberry St. ....yrs., ...mos. ....ds.)

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	black	single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 77 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 240

9-BIRTHPLACE, (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Mosher

(Address) 734 W Mulberry

15-

Filed....., 191.....

Registrar.

OCT 23 1917 ROBERT B. KRAUTH REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 21 1917, that I saw h[illegible] alive on Oct 21 1917, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 22, 1917. (Address) 2nd Generous St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 734 W Mulberry St

19-PLACE OF BURIAL OR REMOVAL, National Cem

DATE OF BURIAL, Oct 23, 1917

20-UNDERTAKER Samuel J Kemsley

ADDRESS 5 S Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9157

CERTIFICATE OF DEATH.

28 D 9157

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 782 Sarah Ann St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bailey

(Residence in Baltimore: No. 782 Sarah Ann St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ——— (Month) (Day) 1 (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lumber
(b) General nature of industry, business, or establishment in which employed (or employer): 089

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Md

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Md

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Bailey

(Address) 782 Sarah Ann

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day) 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.), find that said deceased came to us death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Driscoll M. D.
(Coroner)

Oct 23, 191.. (Address) 512 N Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Oct 25th, 19..

20-UNDERTAKER Samuel Handley

ADDRESS 57 Hillen St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D 9455

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Linden Av. & Madison ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Emily Doyle

(Residence in Baltimore: No. 1648 Division St. St.; ? yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month), (Day), 1 (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Servant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unk

12-MAIDEN NAME OF MOTHER Unk

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Md. General Hospital

(Address) Linden ave.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20 1917, to Oct 22 1917, that I saw her alive on Oct. 22 1917, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Eclampsia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Norris M. D.

10-22, 1917 (Address) Md Gen Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mos 1/2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn

DATE OF BURIAL, Oct 24 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 E Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D-9156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 11 WARD)

REGISTERED NO. C D 9156

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Pohtas

(Residence in Baltimore: No. 207 Hamilton Terrace St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) October (Day) 22, (Year) 1885

7-AGE, 32 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Greece

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Basil Co[illegible]

(Address) 526 W. Baltimore St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 22 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1917, to Oct 22 1917, that I saw him alive on Oct 22 1917, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

.....

.....

..... (Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Diffuse Nephritis

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

10/23, 1917. (Address) Maternity Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 10 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Hamilton Terrace

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, Oct. 24, 1917.

20-UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9157

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clifton Stande

(Residence in Baltimore: No. 5 N Exeter St St.; ...yrs., 3 mos. 9 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	single

6-DATE OF BIRTH, July 12 (Month) (Day), 1913 (Year)

7-AGE, 3 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Agnes Stande

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Smith

(Address) Johns Hopkins Hosp

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct. 21 1917, that I saw h[e] alive on October 21 1917, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Congenital debility

..... (Duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary) Syphilis

..... (Duration) ...yrs. 3 mos. ...ds.

(Signed) Margaret Tyler M. D.

Oct 21, 191... (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5 N Exeter St

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem — DATE OF BURIAL, Oct 23, 191..

20-UNDERTAKER L. R. Cook

ADDRESS 1003 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9458

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 E Madison ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Miller

(Residence in Baltimore: No. 511 E Madison st St.; 60 yrs., 2 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 28th (Month) (Day), 1857 (Year)

7-AGE, 60 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): American Can Co

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John F Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Miller

(Address) 511 E Madison st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21 (Month) (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5 191., to Oct 21 191., that I saw h im alive on Oct. 18 191., and that death occurred, on the date stated above, at 11:50 p.m.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis Pulmonary

(Duration) ? Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) Unknown yrs. mos. ds.

(Signed) Cor E Schmidt M. D.

Oct 24, 191. (Address) 701 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Temple Lutheran Cemetery — DATE OF BURIAL, Oct 25th, 191.

20-UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 23 1917

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9459

CERTIFICATE OF DEATH.

D 9459

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: H WARD)

REGISTERED NO. C 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Grimes

(Residence in Baltimore: No. 2501 N Calvert St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) X

6-DATE OF BIRTH, October 23, 1917
(Month) (Day) (Year)

7-AGE, X yrs. X mos. X da.

If LESS than 1 day, 6 hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lawrence Grimes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cecelia Griffin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence Grimes

(Address) 2501 N Calvert

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 23 1917, to Oct 23 1917, that I saw him alive on Oct 23 1917, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows: Prematurity

(Duration) yrs. X mos. X ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Tuttle M. D.

Oct 23 191 7. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 2501 N. Calvert

Former or usual residence 2501 N. Calvert

19-PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL, 10/23, 1917.

20-UNDERTAKER W. W. Shriver ADDRESS 1015 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9160

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D 9160

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 Ausgust St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kissner

(Residence in Baltimore: No. 2025 Ausgust St.)

yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Single

6-DATE OF BIRTH, Oct. 12 (Month) 12 (Day) — (Year) 1917

7-AGE, ...yrs....mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George H. Kissner

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Julia Kiss

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Kissner

(Address) 2325 Ausgust St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) / 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/14 1917, to 10/23 1917, that I saw h[illegible] alive on 10/22 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Morbus Caeruleus

+ Pemphigus

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible]

10/23, 1917 (Address) 2705 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery

DATE OF BURIAL, Oct. 23 1917

20-UNDERTAKER George F. Ruth

ADDRESS 1735 Halford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9461

CERTIFICATE OF DEATH.

REGISTERED NO. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Virginia Knight

(Residence in Baltimore: No. Odenton Md. St.; ..... yrs., ... mos., ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... June (Month) 5. (Day), 1912. (Year)

7-AGE, ... 5 yrs. 4 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Samuel Knight

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Addie Hood

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Knight

(Address) Odenton Md.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second degree burns. Cause by her dress catching fire while lighting a fire (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Driscoll M. D.

(Coroner.)

Oct 23, 1917. (Address) 512 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Odenton Md. DATE OF BURIAL, Oct 25 19 17.

20-UNDERTAKER A. J. Tasker ADDRESS Odenton Md.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9462

CERTIFICATE OF DEATH.

92 D 9462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kerne

(Residence in Baltimore: No. 222 N. Castle St.: —yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. May - 28, 1867 (Month) (Day) (Year)

7-AGE. 50 yrs. 4 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker 017
(b) General nature of industry, business, or establishment in which employed (or employer): 324

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Gustav Kerne

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Kennard

(Address) Maryland Penitentiary

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October - 23, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October - 4 - 1917, to October - 23 1917, that I saw him alive on October - 23 - 1917, and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ...yrs. ...mos. 19 ds.

(Signed) William F. Seward M. D.

10/23, 191.7. (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 8 mos. 7 ds. In the State —yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 222 N. Castle St.

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Oct. 27 191?

20-UNDERTAKER William Cook ADDRESS 502 E. North Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 9463

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Holzmeier

(Residence in Baltimore: No. 419 N. Gay St

St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, Unknown ....., 1865
(Month) (Day) (Year)

7-AGE, 52 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) C66

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Oct 23 1917, that I saw h[illegible] alive on October 23 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cystonephrosis Rt + Lt.
T. B.?

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. T. Sams M. D.

Oct 23, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 419 N Gay St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, 10/24/1917

20-UNDERTAKER Jack Lewis ADDRESS 141 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9461

CERTIFICATE OF DEATH.

D 9461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Rosenberg

(Residence in Baltimore: No. 7 Irving Place St.; 13 yrs., 0 mos. 0 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) (Day), 1880 (Year)

7-AGE: 37 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore St

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Filed....., 191.....

Registrar.

OCT 23 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 23, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7 1917, to Oct 23 1917, that I saw him alive on Oct. 23 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis + Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism (16 days)

Embolism of abdominal aorta (16 hrs)

(Duration) yrs. mos. ds.

(Signed) Joseph J. Levy M. D.

Oct 23., 191.7 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at residence

Former or usual residence 7 Irving Place

19-PLACE OF BURIAL OR REMOVAL, Workmen circle 2nd Comp.

DATE OF BURIAL, 24 Oct., 191.7

20-UNDERTAKER Jack Lewis

ADDRESS 141 E Baltimore St

Spec.—5-19-13—M. & T.—500 Bks.

D 9465

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 9465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Thames ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wadislaw Genzer

(Residence in Baltimore: No. 1720 Thames St.; — yrs., 10 mos. 20 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. (Month) 2nd (Day), 1916. (Year)

7-AGE, yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Julian Grnzr.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Leokadia Piowrska

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julian Genzer.

(Address) 1720 Thames St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 22 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1917, to Oct. 22 1917, that I saw him alive on Oct. 22 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Rehberger M. D.

Oct. 22, 1917. (Address) 1709 Aliceanna St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary. DATE OF BURIAL, Oct. 24, 1917.

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

D 9166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 9166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 W Franklin St. ST.; 18 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Demuth

(Residence in Baltimore: No. 946 W Franklin St. St.; 84 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, August 6, 1833
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
84 yrs. 2 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 011

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Demuth

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Catherine La Rue

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry A Demuth

(Address) 946 W Franklin St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 23 1917, that I saw h alive on Oct 22nd 191 , and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prostatic Enlargement

3 or 4 days (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H F Hall M. D.

Oct 23, 1917. (Address) 1001 E Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Olivet	Oct 26 1917.
20-UNDERTAKER	ADDRESS
Geo W Little	531 N Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9167

REGISTERED NO. C ....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 E Gettings ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elizabeth Schepers

(Residence in Baltimore: No. 535 E Gettings St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... June (Month) 24 (Day), 1917 (Year)

7-AGE, ... yrs. 3 mos. 28 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Harry J Schepers

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Verna Dockin

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Harry Schepers .....

(Address) ..... 535 E. Gitting St. ....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 22nd (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 22 1917, that I saw h— alive on Oct 22 1917, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

10/23/, 191.7. (Address) 1319 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. A.A. DATE OF BURIAL, Oct 24, 191.7.

20-UNDERTAKER, M. L. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9463

CERTIFICATE OF DEATH.

120 D 9463

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Jaraitis

(Residence in Baltimore: No. 714 N Eutaw St. St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, ...September...., 1874.
(Month) (Day) (Year)

7-AGE, 43 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Tony Jaraitis

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Edna Adroski

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Teresa Jaraitis

(Address) 714 N Eutaw

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/30 1917, to 10/22 1917, that I saw h[im] alive on Oct 22 1917, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH was as follows:*

Empyema Co. of Lung

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos Hein M. D.

10/24, 1917. (Address) Municipal Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 3 ds. In the State yrs. 16 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 714 N Eutaw

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, Oct 24, 1917.

20-UNDERTAKER Jno Gubliauckas — ADDRESS 425 S Paca

Spec.—8-24-14—M. & T.—2000 Bks.

Tony Burres

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9469

CERTIFICATE OF DEATH.

D 9469

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; N 2 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tony Bakus

(Residence in Baltimore: No. 210 W. Camden St. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ~~Oct~~ Sept 28, 1891.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
26 yrs. 1 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Box maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) Mercy Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct. 23 1917, that I saw h m alive on Oct 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Typhoid

(Duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) Edward F. Dunn M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 210 W Camden St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Oct 27 1917

20-UNDERTAKER, John Jakubowski ADDRESS 435 Pine St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9470

CERTIFICATE OF DEATH.

D 9470

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Jarvis ST ST.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Hill

(Residence in Baltimore: No. 405 Jarvis ST St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... occ .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Moses Coleman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mulatto

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Coleman

(Address) 405 Jarvis St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1917, to Oct. 20 1917, that I saw her alive on Oct. 20 1917, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

a. Cerebral Hemorrhage

.....

.....

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bright's

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Robert F. Green M. D.

Oct. 22., 1917. (Address) 120½ Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	....., 191.
20-UNDERTAKER John F. Owens	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9471

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Gutman Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Heinrich

(Residence in Baltimore: No. 608 Gutman Ave St.; ....yrs,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November 2nd, 1839
(Month) (Day) (Year)

7-AGE, 77 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Superintendent
(b) General nature of industry, business, or establishment in which employed (or employer): Hair factory

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Daniel Heinrich

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Pfeffel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Heinrich

(Address) 608 Gutman Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23rd, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22nd 1917, to Oct 23rd 1917, that I saw h— alive on Oct. 23rd 1917, and that death occurred, on the date stated above, at 9.40a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Wellington Boyd M. D.

Oct 23rd 1917. (Address) 2534 Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER William Cook

ADDRESS 3022 West

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 9172

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Babetta Simon

(Residence in Baltimore: No. 2007 Jefferson St.; 29 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
~~Female~~	White	Married

6-DATE OF BIRTH, Oct 18th, 1823 (Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE. (State or Country), German

PARENTS.

10-NAME OF FATHER, John Simon

11-BIRTHPLACE OF FATHER (State or Country), German

12-MAIDEN NAME OF MOTHER Margaret D.

13-BIRTHPLACE OF MOTHER (State or Country), German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Simon

(Address) 2007 Jefferson

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21st, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 — 191 7, to Oct 21 — 191 7, that I saw h — alive on Oct 21 191 7, and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

1. Valvular Dis - Heart -

2.

3.

..... (Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion &

..... (Duration) ... yrs. ½ mos. ... ds.

(Signed) Impossible M. D.

Oct 23, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Oct 24 1917
20-UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9173

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 Cambridge ST ST.; 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Cohen

(Residence in Baltimore: No. 2301 Cambridge ST St.; 12 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, October 24, 1905
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
12 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Cohen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ida Levinsky

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Eutaw St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 9 1917, to Oct 24 1917, that I saw h[im] alive on Oct 23 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

.....

Mitral Insufficiency

..... (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Delated heart

..... (Duration) yrs. 6 mos. ds.

(Signed) Jno. J. McAvoy M. D.

Oct 24, 191.. (Address) 839 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Hebrew Washington Md	Oct 24, 191..
20-UNDERTAKER Jack Lewis	ADDRESS 1411 Eutaw

Cause of DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9171

42 D 9171

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Cumberland ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Anne Bland

(Residence in Baltimore: No. 633 Cumberland St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, July (Month) 16 (Day), 1861 (Year)

7-AGE, 56 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William J. McLaughlin

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Charlotte M. Crosby

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis C. McLaughlin

(Address) 683 Cumberland St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 6 1917, to Oct. 23 1917, that I saw h[er] alive on Oct. 23 1917, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

and exhaustion

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas L. Hood M. D.

Oct 23 1917 (Address) 735 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Oct 25, 191[7]

20-UNDERTAKER W. W. Caulbert

ADDRESS 1624 N[o] Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9475

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9475

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2499 Druid Hill Ave. St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Suter

(Residence in Baltimore: No. 2499 Druid Hill Ave St.; 50 yrs., mos. ds.)

Gen m.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., (Month) ....., (Day) 1849 (Year)

7-AGE, about 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Edw Kelly

11-BIRTHPLACE OF FATHER (State or Country), Irelandt.

12-MAIDEN NAME OF MOTHER Eliza Brannan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo M Suter

(Address) 2499 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

Dr Milton

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1916, to Oct 24 1917, that I saw her alive on Oct 24 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart Disease

(Duration) yrs. 1 mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J F Milton M. D.

Oct 24 1917. (Address) 1303 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Oct 26 1917

20-UNDERTAKER W. M. Caulfield

ADDRESS 1621 W Pratt

Interment Oct

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9176

CERTIFICATE OF DEATH.

115

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Battery Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Francis Klausner

(Residence in Baltimore: No. 1428 Battery Ave St.; 54 yrs., 1 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 10, 1863.
(Month) (Day) (Year)

7-AGE, 54 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Gottlieb Krauth

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Cermandt

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss K. Klausner

(Address) 1428 Battery

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Oct 23 1917, that I saw her alive on Oct 23 1917, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Inflammation of
Gall bladder ?

(Duration) ....yrs....mos. 18 ds.

CONTRIBUTORY (Secondary) Acute pancreatitis

(Duration) ....yrs....mos. 1 ds.

(Signed) Neale Stigler M. D.

10/23., 1917. (Address) 1316 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, 10/25, 1917

20-UNDERTAKER D. Fawn McCully — ADDRESS 130 E. Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 917

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Chapel ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Gossman

(Residence in Baltimore: No. 414 N. Chapel St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, December 6, 1896
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
20 yrs. 10 mos. 16 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Rubin

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Stesula

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Kasper Gossman

(Address)....414 N. Chapel St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 16 1917, to Oct 22 1917, that I saw h[er] alive on Oct 21 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Edward J. Lewis M. D.

10/22, 1917. (Address) 413 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	Oct 24, 1917.

20-UNDERTAKER	ADDRESS
Geo M. Fiore	5109 W. Pr.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-15—M. & T.—500 Bks.

D 9178

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 9178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1372 N Stricker ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Thomas

(Residence in Baltimore: No. 1372 N Stricker St.; 22 yrs., 9 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, 12 (Month) 13 (Day), 1895 (Year)

7-AGE, 22 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Henry Thomas

11-BIRTHPLACE OF FATHER (State or Country). St Mary's Co

12-MAIDEN NAME OF MOTHER Jennie Marshall

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Carroll

(Address) 1372 N Stricker St

15-

Filed ....., 191....

OCT 24 1917 ROBERT R. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct 22 1917, that I saw h[illegible] alive on Oct 20 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(b) Bronchial

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

(Signed) C. H. Barker M. D.

191... (Address) 1403 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 25, 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N Carey

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9479

CERTIFICATE OF DEATH.

17 D 9479

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 695 Pierce ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas E. Chew

(Residence in Baltimore: No. 695 Pierce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Widower.

6-DATE OF BIRTH, Oct (Month) 20. (Day), 1856 (Year)

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal Cart Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Driver

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Gasaway Chew

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Hicks

(Address) 1821 Kavanaugh St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull, causes by his cart being struck by Edmondson Car, and throwing him to the ground (accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Broscoe (Coroner.) M. D.

Oct 20th, 1917. (Address) 512 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Oct 24, 1917

20-UNDERTAKER George H. Holland — ADDRESS 1431 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9480

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 V D 9480

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2531 W. Fairmount ST.: 70 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm E. F. Brown,

(Residence in Baltimore: No. 2531 W. Fairmount St.; yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: May (Month) 5 (Day), 1870 (Year)

7 AGE: 47 yrs. 5 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry G. Brown

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Mary L. Patterson

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah A. Brown
per C. Getz, M. D.

(Address) 2031 W. Fairmount Ave

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 22nd (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24th 1892 ~~191~~, to Oct. 22nd 1917, that I saw him alive on Oct. 22nd, 1917, and that death occurred, on the date stated above, at 5.30 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 25 yrs. 3 mos. 22 ds

Contributory (SECONDARY) Hemorrhage from Lung D.

(Duration) — yrs. — mos. 6 ds.

(Signed) Charles Getz, M. D.

Oct 23rd, 1917. (Address) 1111 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park | DATE OF BURIAL: Oct 25 1917

20 UNDERTAKER: George J. Smith | ADDRESS: 1000 E. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 9181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Marine Hospital 81 REGISTERED NO. C 12

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Haggans.

(Residence in Baltimore: No. U. S. Marine Hospital St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Hospital Record

(Address)

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1917, to Oct 24 1917, that I saw h[illegible] alive on Oct 24 1917, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia of Femoral artery (Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Ulcer R. Gangrene (Duration) yrs. mos. ds.

(Signed) Chas E. Vogel M. D.

Oct 24, 1917. (Address) U. S. Marine Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 19 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence ?

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct. 25, 1917.

20-UNDERTAKER Lenowett & Son ADDRESS 3615 Chestnut Av

OCT 25 1917

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9182 ✓ 64 D 9182

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Jefferson ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward H. Smith

(Residence in Baltimore: No. 1402 Jefferson St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Jan 5 (Month) (Day), 1858 (Year)

7-AGE, 58 yrs. 8 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Steamboat 233

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S. Smith Wife

(Address) 1402 Jefferson St

15-

Filed....., 191.....

Registrar.

OCT 24 1917 HARRY D. ARTEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1916, to Oct 21 1917, that I saw h~~im~~ alive on Oct 21 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coma

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) ~~One~~ yrs. 5 4 mos. ..... ds.

(Signed) W. Wilson M. D.

Oct 23 1917. (Address) 1220 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Oct 25, 191.7

20-UNDERTAKER Chas. G. Bailey — ADDRESS 1421 Jefferson

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

t 104 D 9183

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Yarnall

(Residence in Baltimore: No. Oakwood Catonsville md St.; ....yrs., 2 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 7, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. F. E. Yarnall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maria Perkins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 2 1917, to Oct 24 1917, that I saw her alive on Octbr 24 1917, and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

..... (Duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Congenital debility

..... (Duration) 0 yrs. 10 mos. 17 ds.

(Signed) Henry B. Conrad M. D.

Oct 24, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Oakwood Catonsville Md

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER W. J. Dickenson — ADDRESS North Pa

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9184

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 9184

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Chapel ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Elizabeth Grossman

(Residence in Baltimore: No. 424 N Chapel St.; — yrs., — mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 17, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Fred C Grossman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Leah M. Grossman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Fred C. Grossman

(Address)..... 424 N. Chapel

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 24 1917, that I saw h[illegible] alive on Oct 23 1917, and that death occurred, on the date stated above, at 11-30 m.

The CAUSE OF DEATH* was as follows:

Prematurity (2mos) Birth

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward J. Kent M. D.

10/24, 191.7 (Address) 413 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeem	Oct 25, 191.7
20-UNDERTAKER	ADDRESS
Geo. W. Frank	[illegible]

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D 9485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 17 D 9485

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Camden Station ST. W WARD) REGISTERED No. C

2-FULL NAME Albin Connors

(Residence in Baltimore: No. Philadelphia St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
23 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman B. & O.
(b) General nature of industry, business, or establishment in which employed (or employer): R. R. 086

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. B. Cook

(Address) 1007 W. Baltimore

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull, caused by being thrown by a bridge, while riding on top of tender of Engine (Duration) Accident yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. S. Driscoll M. D.

Oct 24 1917 (Coroner.) (Address) 312 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Philadelphia Pa	Oct. 24, 1917
20-UNDERTAKER Jos. B. Cook	ADDRESS 1007 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 D 9186

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1734 Poplar Grove St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence E. Segar

(Residence in Baltimore: No. 1734 Poplar Grove St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 30, 1914
(Month) (Day) (Year)

7-AGE, 2 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John E Segar

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Beulah J Macneal

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beulah Segar

(Address) 1734 Poplar Grove st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to Oct 22 1917, that I saw h[illegible] alive on October 22 1917, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

.....

.....

Tuberculous Meningitis

..... (Duration) ...yrs. [illegible] mos. 21 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

Oct 23 1917. (Address) 2104 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Oct 26, 1917.
20-UNDERTAKER	ADDRESS
Albert E Fuller	221 N Bradley

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9487

CERTIFICATE OF DEATH.

81 D 9487

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lautner

(Residence in Baltimore: No. 802 S. Linwood Ave. St.; 29 yrs., mos. ds.)

important. See instructions on back of certificate. Entry of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 26, (Day) 1853 (Year)

7-AGE, 64 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Ignatz Lautner

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER Marie Biela

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lautner

(Address) 802 S. Linwood Ave

15-

Filed ....., 191.....

Registrar.

OCT 25 1917 ROBERT J. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 23, (Day) 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1917, to Oct. 23, 1917, that I saw him alive on Oct. 23, 1917, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis,
dont know
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac arrythmia
dont know
(Duration) yrs. mos. ds.

(Signed) J. Edward Norris M. D.

10/24, 1917. (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 802 S. Linwood Ave.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
1st Evangelical Cem.	Oct 25, 1917

20-UNDERTAKER	ADDRESS
H. Sander Son	1710 Pratt St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9189

CERTIFICATE OF DEATH.

1 D 9189

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Lehman ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Grutzner

(Residence in Baltimore: No. 2 Lehman St ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January (Month) 11 (Day), 1850 (Year)

7-AGE, 67 yrs. 9 mos. 11 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joachim Meier

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lizetta Fritze

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Flogel

(Address) 2 Lehman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 23 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1917, to Oct 23 1917, that I saw h Or alive on October 22 1917, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

.....

.....

..... (Duration) ....yrs. 9 mos. ....ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (Duration) ....yrs. 1 mos. ....ds.

(Signed) Asa L Wessels M. D.

Oct 23, 1917 (Address) 2565 Frederick Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Oct 26th, 1917.

20-UNDERTAKER Chas M Dill. ADDRESS 319 Fredk Ave.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 E. Fayette ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grover F. Clemens

(Residence in Baltimore: No. 2011 E. Fayette st. St.; .....yrs.,.....mos.....ds.)

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 28th (Day), 1916 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 10 mos. 25 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Clemens

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City.

12-MAIDEN NAME OF MOTHER Anna Stoecker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Clemens

(Address) 2011 E. Fayette St.

15-

OCT 25 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23rd (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 23 1917, that I saw h[illegible] alive on Oct 23 1917, and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

..... (Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) .....yrs. .....mos. 10 ds.

(Signed) Chas. C. Lemmon M. D.

Oct 24, 1917 (Address) 1811 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cem.	October 26 1917
20-UNDERTAKER Lilly and Zeiler.	ADDRESS 403 N. Wolfe

Spec.—8-24-14—M. & T.—2000 Bks.

D 9490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9490

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; W. Lanv WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Yungunst

(Residence in Baltimore: No. 321 S Chapel St St.: 40 yrs., mos. ds.)

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 9 (Month) (Day), 1860 (Year)

7-AGE, 57 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Geo. Koehring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... George Yungunst

(Address)..... 321 S. Chapel St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Oct 23 1917, that I saw her alive on Oct 23 1917, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

Duration Unknown

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) H. Merkel M. D.

Oct 23, 1917. (Address) St Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 321 S Chapel St

19-PLACE OF BURIAL OR REMOVAL, Our Redeemer Cem — DATE OF BURIAL, Oct. 26, 1917.

20-UNDERTAKER Lilley & Geiser — ADDRESS 409 S Mopt St.

17
3 8

Samuel S. Lightfoot

HEALTH DEPARTMENT—CITY OF BALTIMORE

8 D 9191

CERTIFICATE OF DEATH.

184 D 9191

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1369 Mulcoster St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME S. S. Lightfoot

(Residence in Baltimore: No. 1369 Mulcoster St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Married

6-DATE OF BIRTH, Dec. 21, 1887
(Month) (Day) (Year)

7-AGE, 30 yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Runner
(b) General nature of industry, business, or establishment in which employed (or employer): 386

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Scott Lightfoot

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mahan

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1369 Mulcoster

15-

OCT 25 1917 ROBERT B. KNAUER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malleable Goitre
with a fibrous Growth
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart Disease
Duration yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
Oct 25, 191. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds. None

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Oct. 25, 1917

20-UNDERTAKER James H. Dennis — ADDRESS 1303 Preston

Spec.—8-24-14—M. & T.—2000 Bks.

D 9192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9192

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lavinia Johnson

(Residence in Baltimore: No. see above St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Col	Widow

6-DATE OF BIRTH. Oct 21, 1865 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
52 yrs. — mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 076

877

9-BIRTHPLACE. (State or Country), Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Lewis

(Address) 1918 Brunt St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22-17, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-2-17 191, to 10-22-17 191, that I saw h... alive on " 191, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Debility

..... (Duration) ... yrs. 2 mos. ... ds.

(Signed) J. H. Carden M. D.

10-22-17, 191... (Address) 1524 Orleans ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Oct 24 191 7.

20-UNDERTAKER James H. Penn

ADDRESS 1303 Brunt St

Important. See instructions on back of certificate.

D 9193

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 ✓ D 9193

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 773 Bradley St. 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis E. Hoad

(Residence in Baltimore: No. 773 Bradley St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Mar 16, 1896 (Month) (Day) (Year)

7 AGE: 21 yrs. 7 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

243

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Jno. H. Hoad

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Howard

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H. Hoad
(Address) 773 Bradley St

15
Filed OCT 25 1917, 191 ... ROBERT B. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 22, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1917, to Oct 22 1917, that I saw h[illegible] alive on Oct. 22 1917, and that death occurred, on the date stated above, at 5.30 p.m.
The CAUSE OF DEATH* was as follows:

Ac. Pneumonia
Tuberculosis

(Duration) ... yrs. 1 mos. ... ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jam[illegible] M. D.
Oct. 24, 1917 (Address) 1006 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Int Auburn — DATE OF BURIAL: Oct 25, 191[illegible]

20 UNDERTAKER: Daniel Easton — ADDRESS 916 [illegible] Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9191

CERTIFICATE OF DEATH.

10 D 9191

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 S. Central Ave ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoinette Demeo

(Residence in Baltimore: No. 326 S. Central Ave St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 15 (Day), 1916 (Year)

7-AGE, 1 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Angelo Demeo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Carmela Martino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. Esposito

(Address) 6 E. Caroline St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1917, to Oct. 24, 1917, that I saw her alive on Oct. 22, 1917, and that death occurred, on the date stated above, at 7 45 A. m.

The CAUSE OF DEATH* was as follows:

Pleo Cavities

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Eugene L Esposito M. D.

Oct. 24, 1917. (Address) 2314 E. Baltic St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Oct. 25, 1917

20-UNDERTAKER Wendell Leppel Son

ADDRESS 330 S. Bond St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9495

D 9495

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 S. Belnord Ave (St.) 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Zabrowska

(Residence in Baltimore: No. 808 S. Belnord Ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan. (Month) 17 (Day) 1857 (Year) ~~1859~~

7-AGE, 60 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ludwig Zamkowski

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Wozniak

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Mann

(Address) 808 S. Belnord Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2 1917, to Oct. 23 1917, that I saw h e alive on Oct. 23 1917, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .....yrs. .....mos. 21 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Henry B. Haley M. D.

Oct 24, 1917. (Address) 2002 Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Kostka	Oct. 26, 1917
20-UNDERTAKER	**ADDRESS**
Stephen J. Walkowski	1912 Hanover

OCT 25 1917 ROBERT R. KRAUTER

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9496

CERTIFICATE OF DEATH.

37 D 9196

1-PLACE OF DEATH St. Vincent's Inf. Asylum REGISTERED NO. C

CITY OF BALTIMORE: (No. 1401 Division ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Basil Meurkel

(Residence in Baltimore: No. 1401 Division St.; ..... yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Wht.	Single.

6-DATE OF BIRTH, Oct (Month) 20 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. 4 ds.	.... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, John Skuhra

11-BIRTHPLACE OF FATHER (State or Country), Holland.

12-MAIDEN NAME OF MOTHER Julia Meurkel

13-BIRTHPLACE OF MOTHER (State or Country), Charleston S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. P. Rousseau

(Address) 1214 Madison Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Oct 24 1917, that I saw him alive on Oct 23 1917, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

1. Hereditary Syphilis.

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leonard M.C. Asher M. D.

....., 191... (Address) 1114 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. 4 ds.

Where was disease contracted, if not at place of death? The Word

Former or usual residence 1401 Division St.

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Oct 25, 1917

20-UNDERTAKER A. Fahey & Son — ADDRESS 606 Lafayette Ave

Important. See instructions on back of certificate.

D 9197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9197

CERTIFICATE OF DEATH.

REGISTERED No. C 1755

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleonora G Beale

(Residence in Baltimore: No. 1823 Penrose ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	wh	Single

6-DATE OF BIRTH, July 7, 82
(Month) (Day) (Year)

7-AGE, 25 yrs. 3 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home 070
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Buffalo NY,

PARENTS.

10-NAME OF FATHER, William Beale

11-BIRTHPLACE OF FATHER (State or Country), NY.

12-MAIDEN NAME OF MOTHER Maria Penbroke

13-BIRTHPLACE OF MOTHER (State or Country), NY

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Beale

(Address) 1823 Penrose

15-

OCT 25 1917 ROBERT B. KRAUTZ

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic shock
by street car
accident (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Hunt Cumley M. D.
(Coroner.)

Oct 25, 1917 (Address) 4 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Edmondson Ave Randall H,

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem DATE OF BURIAL, Oct 27th, 1917

20-UNDERTAKER Joseph L Cook ADDRESS 1002 Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

P D 9198 — 81 ✓ — D 9198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. 3922 Park Heights Av St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernesting Hochheimer

(Residence in Baltimore: No. 3922 Park Heights Av St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept. (Month) 8th (Day), 1850 (Year)

7-AGE, 67 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Hochheimer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Roza Kremer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Hochheimer

(Address) 3922 Park Heights av

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Oct. 24 1917, that I saw her alive on Oct 24 1917, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ....yrs. ....mos. 12 hrs.

CONTRIBUTORY (Secondary) Transform aneurysm of aorta (Duration) ....yrs. 6 mos. ....ds.

(Signed) Jno. C. Sutton M. D.

Oct. 24, 1917. (Address) 223 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Har Sinai — DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER Hart Goodman — ADDRESS 1616 Mon Ave

Important. See instructions on back of certificate.

OCT 25 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9199

CERTIFICATE OF DEATH.

30 ✓

D 9199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Park Heights ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Moore

(Residence in Baltimore: No. 3925 Park Heights Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, April (Month) 29 (Day), 1906 (Year)

7-AGE, 12 yrs. 5 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo R Moore

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Effie Fosnell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Effie Moore

(Address) 3925 Park Hts

15-

Filed ....., 191.....

Registrar.

OCT 25 1917 ROBERT R. KRAUTER

Dr Bubert

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 9th 1917, to Oct 24th 1917, that I saw h[illegible] alive on Oct 24th 1917, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

..... (Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ethel D. Bubert M. D.

Oct 24, 1917. (Address) 1154 Park Hts Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. Is the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bair Cemetery — DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER W J Dickner & Son — ADDRESS North Pa

important. See instructions on back of certificate.

P

D 9500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9500

CERTIFICATE OF DEATH.

175

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garrett Noble

(Residence in Baltimore: No. Construction Camp at Locust Point. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single.

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 0 4 0

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, //

11-BIRTHPLACE OF FATHER (State or Country), //

12-MAIDEN NAME OF MOTHER //

13-BIRTHPLACE OF MOTHER (State or Country), //

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital

(Address) Green & Lombard Sts

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Fracture of Skull and internal injuries. Caused by being struck by B. & O. R. R. Engine, (accidental)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Driscoll M. D.
(Coroner)
Oct 22, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
PUBLIC CEMETERY	OCT 25 1917, 19...
20-UNDERTAKER	ADDRESS
Commissioner Health.	

For Wm. E. WOODALL.

IMPORTANT. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9501 CERTIFICATE OF DEATH. 15 V D 9501

1-PLACE OF DEATH Mpl. General Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Bickley

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, October (Month) 21 (Day), 1917 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 3 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Hill

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Albertha Bickley

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191...

Registrar.

OCT 25 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 21 1917, to Oct. 21 1917, that I saw him alive on Oct. 21 1917, and that death occurred, on the date stated above, at 10:12 a.m.

The CAUSE OF DEATH* was as follows:

.....

Congenital Malformation

..... (Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

10-21, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State Ohio yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, OCT 25 1917, 191...

20-UNDERTAKER Commissioner Health. ADDRESS

Per Wm E. WOODALL

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9502

CERTIFICATE OF DEATH.

51 D 9502

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S. East Ave, ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Female child of John P. & Sarah E. Witzke

(Residence in Baltimore: No. 416 S. East ave St.; ....yrs., ...mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... Oct. (Month) 25 (Day), 1917 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John P. Witzke

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Sarah E. Thornhill

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Witzke

(Address) 416 S. East Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 25 1917, to Oct 25 1917, that I saw h.e alive on Oct 25 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

.....Strangulation.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Dr. Frank A. Glantz M. D.

Oct. 25, 1917. (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Schwartz Cemetery	Oct. 26, 1917
20-UNDERTAKER	**ADDRESS**
Zirkler & Zirkler	1737 E. Eager St.

important. See instructions on back of certificate.

D 9503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 ...WARD)

REGISTERED No. C 175

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick E. Wickel.

(Residence in Baltimore: No. University Hospital St.; yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November, 1 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman 666
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe business

666

9-BIRTHPLACE (State or Country). Dayton Ohio

PARENTS.

10-NAME OF FATHER. Frederick F. Wickel.

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Louisa Fishbaugh

13-BIRTHPLACE OF MOTHER (State or Country). Phil. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. E. Wickel.

(Address) Fort Benj. Harrison Ind

15-

Filed ....., 191.....

Registrar.

OCT 25 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia following Amputation of Leg, which was caused by Gangrene Varicose Veins (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental (Duration) yrs. mos. ds.

(Signed) C. A. Loscalzo M. D. (Coroner.)

Oct 25, 1917 (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Dayton Ohio

DATE OF BURIAL, Oct 28, 1917

20-UNDERTAKER Jacob J Cook

ADDRESS 1003 W Balto St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cause of death in plain terms so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9507

CERTIFICATE OF DEATH.

90 D 9507

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Gorsuch Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A Kaiser

(Residence in Baltimore: No. 904 Gorsuch Ave St.; ... Ward.)

Like Home

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, September 16th, 1848
(Month) (Day) (Year)

7-AGE 69 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Murray

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Martha A Hollis

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Housman

(Address) 904 Gorsuch Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23rd, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 19th 1916 to October 23rd 1917, that I saw her alive on October 23rd 1917, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Dil. of Heart
(Duration) ....yrs. 6 mos. ....ds.
Chronic Bronchitis
(Secondary)
(Duration) 2 yrs. ....mos. ....ds.
(Signed) Wm. H. Mc[illegible] M. D.
Oct. 24, 1917, (Address) 1031 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL New Cathedral | DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER Robert J Turner | ADDRESS 422 N. Broadway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9505

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. N.E. cor Beech & Allandale St.; 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Keilholtz Towles

(Residence in Baltimore: No. N.E. cor Beech & Allandale St.; 46 yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, September 18, 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Otis Keilholtz

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emily Shamessy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard M. Towles

(Address) Beech & Allandale Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Oct 24 1917, that I saw h[illegible] alive on Oct 23 1917, and that death occurred, on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH* was as follows:

Mitral valve insufficiency & compensation & Cardiac Nephritis (Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) [illegible] (Duration) [illegible] yrs. 6 mos. [illegible] ds.

(Signed) Stephen Cole M.D. M. D.

Oct 24, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER Stewart Memorial Co — ADDRESS 1088 W. North Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9506 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 9506

CERTIFICATE OF DEATH.

× 91

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. John Hopkins Hosp.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Eveling.

(Residence in Baltimore: No. Roseville Maryland St.; yrs., 3 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 8 1917, 1
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Eveling

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ethel Seling

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thelma Yentz

(Address) J. H. H.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Oct 25 1917, that I saw him alive on Oct. 25 1917, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) marasmus (congenital)

(Duration) ...yrs. 2 mos. ...ds.

(Signed) Margaret Tyler M. D.

Oct. 25, 1917 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Roseville Maryland

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, Oct 27, 1917.

20-UNDERTAKER Christian Miller ADDRESS 2334 Jefferson St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

923 Hamilton Ave

D 9507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9507

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 St Paul ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olivia J. Hammer

(Residence in Baltimore: No. 706 St Paul St.; 75 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 25th 1832, 1 (Month) (Day) (Year)

7-AGE, 85 yrs. 7 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Frederick City Md

PARENTS.

10-NAME OF FATHER, James Jefferson Hammer

11-BIRTHPLACE OF FATHER (State or Country), Charlotte, Albemarle Co. Va.

12-MAIDEN NAME OF MOTHER Jane McElderry

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma B. Hammer

(Address) 712 Lemmox St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12 1917, to Oct. 25 1917, that I saw her alive on Oct. 25 1917, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Cold, then Grip & then dropsical state that came with it. Chronic Nephritis

Contributory (Secondary) Senile Degeneration (Duration) 1 yrs. ... mos. ... ds.

Senile Degeneration (Duration) 8 yrs. ... mos. ... ds.

(Signed) H. H. Simmons M. D.

Oct. 25 1917. (Address) 823 Hamilton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount — DATE OF BURIAL, 10-27, 1917

20-UNDERTAKER John B Spence — ADDRESS 1325 N Gay St

Important. See instructions on back of certificate.

D 9503

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D 9503

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No 1814 N. Fremont St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ferdinand F. Dietsch

(Residence in Baltimore: No. 814 N. Fremont St.: 64 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widr

6 DATE OF BIRTH: Feb. 24, 1845 (Month) (Day) (Year)

7-AGE: 72 yrs. 8 mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Frederick Dietsch

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Philippina Dunesh

13-BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. West

(Address) 1403 Central Ave.

15. Filed Oct 25 1917 J. Wilkins, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. 24, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24" 191 . to, Oct. 24" 1917. that I saw h[im] alive on Oct. 24" .1917. and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

3 hrs.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Nephritis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) W B Rieger M. D.

Oct. 25, 1917. (Address) 887 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Oct 27 1917

20 UNDERTAKER: Wilbur H. Herring

ADDRESS: 1422 Druid Hill Ave

Coroner.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied.

Spec.—5-19-13—M. & T.—500 Bks.

D 9509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9509

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Hanover ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Crouch

(Residence in Baltimore: No. 117 Hanover St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.): Married

6-DATE OF BIRTH: March 21st, 1844 (Month) (Day) (Year)

7-AGE: 73 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): (Grocers)

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: William Crouch

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Martha Ingram

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Delaplaine M.D.

(Address) 601 N. Carrollton Ave

15-

Filed....., 191... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22nd, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 1916, to October, 1917, that I saw him alive on October 22nd 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Howard Delaplaine M. D.

601 N. Carrollton Ave, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct. 26, 1917.

20-UNDERTAKER John O. Murdock — ADDRESS 1208 W. Fayette

D 9510

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

81

D 9510

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Wenonah Apts. Park ave St. Monument ; WARD) — (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Bell Hall

(Residence in Baltimore: No. Wenonah Apartments St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb 28, 1838 (Month) (Day) (Year)

7 AGE: 79 yrs. 7 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: House duties (b) General nature of industry, business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: Thomas G. Monroe

11 BIRTHPLACE OF FATHER (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary B. Haxall

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Bell Perkins

(Address) 414 Franklin St Richmond Va

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 25, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15", 1917, to, Oct 24 1917, that I saw h[illegible] alive on Oct 25" 1917, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(Duration) ..... yrs. ..... mos. 6 ds

Contributory (SECONDARY) Arterial Sclerosis

(Duration) 3 yrs. mos. ds.

(Signed), Mary B Barnes M. D.

Oct 25", 1917 (Address) 1607 Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Oct. 26, 1917

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette St.

state CAUSE OF DEATH in plain terms. so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9511

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1820 Simpson ST.; 9 WARD) REGISTERED NO. C 120

2-FULL NAME Sophia Hieronimus

(Residence in Baltimore: No. 1820 Simpson St.; 45 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 15 (Day), 1872 (Year)

7-AGE, 45 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at Home
(b) General nature of Industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George Young

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Gesina E Berlin

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Hieronimus

(Address) 1820 Simpson

15-

Filed....., 191.....

Registrar.

Dr Fair 12 E-25th

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Oct 24 1917, that I saw h[illegible] alive on Oct 23 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Tait M. D.

Oct 25, 1917, (Address) 1[illegible] E 25th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Oct 26, 1917

20-UNDERTAKER Mullan Cork

ADDRESS 502 E North Ave

D 9512 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 9512

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 E Pratt ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Waranish

(Residence in Baltimore: No. 1015 E Pratt St.: 7 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	White	Married

6-DATE OF BIRTH, Unknown (Month), (Day) 1 (Year)

7-AGE, 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Louis Waranish

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Waranish

(Address) 1015 E. Pratt St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Chas. J. Gue, Jr. M. D.
(Coroner.)
Oct 25, 1917 (Address) 1 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rawing Run	Oct 27, 1917
20-UNDERTAKER	ADDRESS
J. Leinster & Bro.	1107 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9513 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Eye & Ear Infirm (St. 11 WARD) REGISTERED No. C 167

2-FULL NAME Ruby A. Cobley

(Residence in Baltimore: No. Md. Eye & Ear Infirm St.; yrs., mos. 2 days.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fmal	Wht	Single

6-DATE OF BIRTH, May 26, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 4 mos. 30 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John C. Cobley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER Emma Lehig

13-BIRTHPLACE OF MOTHER (State or Country), N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) Pikesville

15-

Filed....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns by Coal Oil Explosion

(Duration) 1 hr. mos. ds.

CONTRIBUTORY (Secondary) Burns

(Duration) yrs. mos. ds.

(Signed) Emil A. Loos M. D.
(Coroner.)

....., 191.. (Address) Pikesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. In the State 2 yrs. mos. ds.

Where was disease contracted, if not at place of death? Pikesville Md

Former or usual residence Pikesville Md

19-PLACE OF BURIAL OR REMOVAL, Woodlawn (Oct 31) DATE OF BURIAL, ..., 191..

20-UNDERTAKER Leopold Ott ADDRESS 102 W Baltimore

Important. See instructions on back of certificate.

D 9511

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 D 9511

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 W. Biddle ST. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Bowser

(Residence in Baltimore: No. 225 W Biddle St.; 56 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Colored	Widower

6-DATE OF BIRTH ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE 56 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Pri Family 021

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daughter Pearl Gowens

(Address) 235 W Biddle St

15

Filed OCT 26 1917 ROBERT R. KRAUTER, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct (Month) 24th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21st, 1917, to Oct 24th 1917, that I saw him alive on Oct 23rd, 1917, and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory (SECONDARY) Heart Weakness (Duration) — yrs. — mos. 6 ds

(Signed) Dane J Bell M. D.

Oct 25th, 1917 (Address) 1516 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death?

Former or usual residence Balto.

19-PLACE OF INTERMENT OR REMOVAL Baltimore National DATE OF BURIAL Oct 26 1917

20-UNDERTAKER Compton Mrs Robert A Elliott ADDRESS 606 East

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9515

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Sharp ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Henry Rinsall

(Residence in Baltimore: No. 1020 Sharp St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, 2 July (Month) (Day), 1872 (Year)

7-AGE. 45 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Roofer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Ed. Rinsall

11-BIRTHPLACE OF FATHER (State or Country). Ireland Md.

12-MAIDEN NAME OF MOTHER Mary J. Hyson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Rinsall

(Address) 1020 Sharp St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 191 , to Oct 25 191 ,

that I saw h[illegible]alive on Oct 25 191 ,

and that death occurred, on the date stated above, at 2.15 p m

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

.....

.....

..... (Duration) ....yrs. 1 mos....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ....yrs. 1 mos....ds.

(Signed) [illegible] M. D.

Oct 25, 191 7 (Address) 835 Lyndhurst

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Oct 27, 191 7.

20-UNDERTAKER Wm Leach

ADDRESS York Road

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9516

CERTIFICATE OF DEATH.

154 D 9316

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 N Carolina ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A Reed (Reed)

(Residence in Baltimore: No. 1208 N Carolina St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb 20, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 6 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Leo Young

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Margaret Anson

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Morris

(Address) 1208 N Carolina St

15-

OCT 26 1917 ROBERT R. KRAUTER SUPT. REGISTRATION

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1917
(Month) (Day) (Year)

17-C I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Oct 24 1917, that I saw her alive on Oct 24 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Senile Decay — 1d
Hard Pulse — 2d
Duration 6 Weeks

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ....yrs. 1 mos. 15 ds.

(Signed) Geo L Milling M. D.

Oct 26 1917 (Address) 6 N Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	Oct 27, 1917

20-UNDERTAKER	ADDRESS
J. E. McKnew & Son	Almond Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9517.

CERTIFICATE OF DEATH.

D 9517.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Little

(Residence in Baltimore: No. 8 academy ave. Arlington Md.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	White	Widow

6-DATE OF BIRTH, Dec. (Month) 21 (Day), 1875 (Year)

7-AGE, 41 yrs. 8 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Co Md.

PARENTS.

10-NAME OF FATHER, E. L. Berryman

11-BIRTHPLACE OF FATHER (State or Country), Balto. co Md.

12-MAIDEN NAME OF MOTHER Mary R. Constantine

13-BIRTHPLACE OF MOTHER (State or Country), Balto. co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Eigenbrode

(Address) 4311 Belvidere ave

15-

Filed Oct 25, 1917 .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) / 25 (Day) / 17, 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1917, to October 25 1917, that I saw her alive on Oct. 25 1917, and that death occurred, on the date stated above, at 2.30 4/3 m.

The CAUSE OF DEATH* was as follows:

..... Typhoid Fever .....

..... (Duration) ... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) ... Lobar pneumonia.

..... (Duration) ... yrs. ... mos. 10 ds.

(Signed) ... J. Edward Toms ... M. D.

10/25/, 191.7 (Address) ... St. Josephs Hos.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 1 mos. 3 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 8 academy ave. Arlington

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Oct. 27, 191.7

20-UNDERTAKER W J Tuckner

ADDRESS North Ave

D 9518

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

1917 D 9518

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Jordan ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah Blumey

(Residence in Baltimore: No. 913 Jordan St.; 6 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7-AGE: 28 yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Jno. Ringold

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Johnson

(Address) 913 Jordan St.

15- ...

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27, 1917, to, Oct 27 1917, that I saw h-e alive on Oct 27 1917, and that death occurred, on the date stated above, at 7 50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs 3 mos — ds.

Contributory (SECONDARY) Hypertrophied Heart

(Duration) yrs 3? mos ... ds.

(Signed), W. A. Pettigrew M. D.

Oct 25, 1917 [Address] 814 Hollins St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 24, 1917

20-UNDERTAKER: Wilbert Brown Co. — ADDRESS 114 St.

TION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9519

CERTIFICATE OF DEATH.

100 D 9519

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 N Smallwood ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie E Gibson

(Residence in Baltimore: No. 2101 N. Smallwood St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widd

6-DATE OF BIRTH, May 5, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Waite Mayo car Lines

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lawrence D Gibson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Coale

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Coale

(Address) 2101 N Smallwood

15-

ROBERT P. KRAUTER

Filed OCT 26 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1917, to Oct 24 1917, that I saw her alive on Oct 23 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

.....

.....

Acute Mayocarditis

..... (Duration) yrs. 2 mos. 22 ds.

CONTRIBUTORY (Secondary) Chronic Tonsilitis

..... (Duration) 3 yrs. mos. ds.

(Signed) M. Altenberg M. D.

10-24-, 1917 (Address) 1204 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. dr. In the State yrs. mos. dr.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park C. DATE OF BURIAL, Oct 26, 191...

20-UNDERTAKER Euston & Tuxedo ADDRESS 2624 Vanc

D 9520

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 9520

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. University Hospital St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Lewis

(Residence in Baltimore: No. 20 S. Hocklon St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmale | 4-COLOR OR RACE, Col. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds. | If LESS than 1 day, hrs. or mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Packer pr 086
(b) General nature of industry, business, or establishment in which employed (or employer): Glass house

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Gross.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Emma Ashland

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard A. Gross

(Address) 20 S. Hocklon St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shock following Amputation of both thighs and fracture of Elbow. Caused by burns received by B. & O. Explosion (Accidental) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. L. Draicer M. D.
(Coroner.)

Oct 27th, 1917. (Address) 312 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. 1 ds. In the University Hospital State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery | DATE OF BURIAL, Oct 29 1917

20-UNDERTAKER Charles B. Jones | ADDRESS 235 Pine St

OCT 26 1917

important. See instructions on back of certificate.

D 9521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 D 9521

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hosp St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Corpen

(Residence in Baltimore: No. St. Agnes Asylum St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 15, 1917
(Month) (Day) (Year)

7-AGE, 1 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?
....yrs. 1 ....mos. 5 ....ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Mary Corpen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Baltimore

13-BIRTHPLACE OF MOTHER (State or Country), 4

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister of

(Address) St. Agnes Asylum

15-

Filed OCT 26 1917, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner)

Oct. 24, 1917 (Address) 1911 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Baltimore

Former or usual residence Baltimore

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITA

DATE OF BURIAL, OCT. 25. 1917

20-UNDERTAKER Commissioner Health, Per. Wm. E. Woodall

ADDRESS

Morgue

important. See instructions on back of certificate.

D 9522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH En route from Tappahanock Va to Balto REGISTERED No. C
CITY OF BALTIMORE (No. on Steamer Potomac. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warner E. Curley.

(Residence in Baltimore: No. Detroit Mich. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know., / (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
23 yrs. – mos. – ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Photographer.
(b) General nature of industry, business, or establishment in which employed (or employer): D.86

9-BIRTHPLACE, (State or Country), Alexandria Va.

PARENTS.

10-NAME OF FATHER, Albert Curley.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Annie B. Davis.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Albert Curley. (father)
(Informant)
(Address) Tappahanock Va.

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)
Oct, 26, 1917. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence Detroit Mich.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Alexandria Va	Oct 26 1917
20-UNDERTAKER	ADDRESS
Armstrong Dem Co	715 Light St

important. See instructions on back of certificate.

OCT 26 1917 ROBERT B. KRAUTER

Spec.—5-19-13—M. & T.—500 Bks.

D 9523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 9523

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 South ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Bidale

(Residence in Baltimore: No. 604 South St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, April (Month) 12 (Day), 1836 (Year)

7-AGE, 81 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Meleis

(Address) 604 South St.

15-

Filed ....., 191....

OCT 26 1917 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Oct 25 1917, that I saw h— alive on Oct 25 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw. F. Reinhardt M. D.

Oct 26, 1917. (Address) 604 South St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct. 26 1917.

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9524

CERTIFICATE OF DEATH.

28 D 9521

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1721 Pennsylvania ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Dixon

(Residence in Baltimore: No. 1721 Pennsylvania St.; 9 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	Colored	single

6-DATE OF BIRTH, ... December ..... (Month) 1 (Day), 1895 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 970 .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Sallie Dixon

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lida Brooks

(Address) 1707 Pennsylvania Ave

15-

Filed....., 191.....

Registrar.

OCT 26 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct- 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct- 7 1917, to Oct-24 1917, that I saw h.. alive on Oct-24 1917, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Primary

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 25, 1917 (Address) 1402 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 26 1917.

20-UNDERTAKER Edward Ringgold

ADDRESS 463 N Carey

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9525

CERTIFICATE OF DEATH.

D 9525

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Mcculloh St. 13 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Kushnick

(Residence in Baltimore: No. 2527 Mcculloh St St.: 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Aug (Month) 18 (Day) 1864 (Year)

7-AGE, 53 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clothing 080
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Finkom

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Finkom

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Lewis

(Address) ..... 1411 Ehald

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Oct 25 1917, that I saw h.. alive on Oct 25 1917, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Uremia Poisoning

Duration 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

Duration yrs. mos. ds.

(Signed) E. H. Cushman M. D.

10/23/17 (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Washington Rd	10/26 191..

20-UNDERTAKER	ADDRESS
Jack Lewis	1411 Ehald

Spec.—2-24-14—M. & T.—2000 Bks.

D 9526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 9526

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Kirk ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Anderson

(Residence in Baltimore: No. 019 Kirk St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Blk	Single

6-DATE OF BIRTH, July (Month) 25 (Day), 1886 (Year)

7-AGE	If LESS than 1 day,
31 yrs. 3 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of Industry, business, or establishment in which employed (or employer)..... D4

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm J. Anderson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Anna Ruck

13-BIRTHPLACE OF MOTHER (State or Country), West Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Anderson

(Address) 1119 Kirk St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26th 1917, to Oct 24 1917, that I saw her alive on Oct 23 1917, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Gustav Goldmann M. D.

Oct 24, 1917 (Address) 656 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dr Auburn Cem	Oct 27 1917
20-UNDERTAKER Samuel Kemsley	ADDRESS 538 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

D 9527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9527

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Burgess

(Residence in Baltimore: No. 1731 William St St.; 1 yrs., 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. May 16, 1916 (Month) (Day) (Year)

7-AGE. 1 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. Burgess

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Katherine Cronin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15- OCT 20 1917 ROBERT R. KUETER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 11 1917, to Oct 24 1917, that I saw h er alive on October 24 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion (acute).

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 2 mos. ds.

(Signed) W. Sydney T. Tyler M. D.

Oct 24, 1917. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1731 William St

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. R. C. DATE OF BURIAL, Oct 26..., 1917.

20-UNDERTAKER Wm. P. Gleason ADDRESS 422 Light St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9523

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 5 WARD)

REGISTERED NO. C

2-FULL NAME Anna Segal

(Residence in Baltimore: No. 1703 Jefferson St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb 1907 (Month) (Day) (Year)

7-AGE, yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 600

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Eli Segal

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER Jennie Rasman

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Segal

(Address) 1703 E. Jefferson St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 26 1917, that I saw her alive on Oct 26 1917, and that death occurred, on the date stated above, at 1.05 p.m.

The CAUSE OF DEATH* was as follows:

gastro-intestinal indigestion

acute

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Margaret Tyler M. D.

Oct. 26 1917. (Address) Johns Hopkins Hosp.,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1703 Jefferson St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER Jack Levin

ADDRESS 1411 E Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9529

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 9529

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N. Madiera ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Smetana

(Residence in Baltimore: No. 710 N. Madiera St.: 25 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Not Known, 1
(Month) (Day) (Year)

7-AGE, 56 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Blazej Smetana

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Smetana

(Address) 710 N Madiera St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1917, to Oct 25 1917, that I saw him alive on Oct 25 1917, and that death occurred, on the date stated above, at 10 50 A.M.

The CAUSE OF DEATH* was as follows:

.....
.....Pulmonary Tuberculosis
.....
..... (Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration) yrs. mos. ds.

(Signed) John Girshwood M. D.

Oct 26, 1917. (Address) 102 E 25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct 27 1917.
20-UNDERTAKER	ADDRESS
Frank Brack Son	1906 Eastlake

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9530 — 175 ✓ — D 9530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital, WARD) 7

2-FULL NAME Julia Stolba

(Residence in Baltimore: No. 814 n Castle St.; Yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED No. C

important. See instructions on back of certificate. — OCCUPATION IS very

344

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 33 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Factory 017

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Pirka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Marie Stverak

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Pirka

(Address) 814 n Castle St

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Femural & 2 ribs
Lumber Northern accidental
by Automobile Immediate

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) James M. Fenlon M. D. (Coroner.)

Oct 28 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Cor. Cary & Lanvale Sts

Former or usual residence 814 n Castle St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill	Oct 29 1917

20-UNDERTAKER	ADDRESS
Frank Coachson	1906 Ashland Ave

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9531 D 9531

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J Davis

(Residence in Baltimore: No. Avon Apartments, Read St.; 35 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, June (Month) 14 (Day), 1876 (Year)

7-AGE, 41 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Steam Sailor

9-BIRTHPLACE, (State or Country) Indiana

PARENTS.

10-NAME OF FATHER, William Davis

11-BIRTHPLACE OF FATHER (State or Country), Wales

12-MAIDEN NAME OF MOTHER, Marguerite James

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lola Franke

(Address) Avon Apts Read St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Oct 25 1917, that I saw him alive on Oct 25 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Strangulation from fluid in Throat

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of left side of Throat (Tonsil & Palate) (Duration) 1 yrs. ....mos. ....ds.

(Signed) W. G. Smith M. D.

Oct 25, 1917 (Address) 1184 Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1 ds. In the State 35 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct 27" 1917

20-UNDERTAKER Chas F Evans & Sn — ADDRESS 118 W Mt Royal

D 9532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 ✓ D 9532

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 19 Joseph Hospital St. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Bronislaus Zielinski

(Residence in Baltimore: No. 925 Fell st.

St 8 yrs., 10 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec 30, 1908
(Month) (Day) (Year)

7-AGE, 8 yrs. 10 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Frank Zielinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anna Drezdzak

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Zielinski

(Address) 925 Fell

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jury
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, accidental
while building fire
at 925 Fell st
(Duration) ....yrs....mos....ds.

CONTRIBUTORY
(Secondary)
(Duration) ....yrs....mos....ds.

(Signed) J. H. Mitchell Jr. M. D.
(Coroner.)
Oct 26, 1917. (Address) 40 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State 1 Mon Lifelong yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 925 F

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Oct 27, 1917

20-UNDERTAKER Wm Hawkins

ADDRESS 1618 Eastern

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 9533

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 E Chase St.; 8 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. May

(Residence in Baltimore: No. 2327 E Chase St.; 8 yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug 16th (Month) (Day), 1909 (Year)

7-AGE, 8 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), City

PARENTS.

10-NAME OF FATHER. Caspar J. May

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine L. Lindenstruth

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Casper J. May

(Address) 2327 E Chase

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21st 1917, to Oct 25 1917, that I saw h[illegible] alive on Oct 25 1917 and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stom & Gastro Enteritis

(Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs....mos....ds.

(Signed) W. McCathran M. D.

Oct 26, 1917 (Address) Emerson Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Balto Cem,	Oct 27, 1917
20-UNDERTAKER Philip Herring	ADDRESS 2016 Aliceanna

Spec.—8-24-14—M. & T.—2000 Blks.

D 9531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9531

CERTIFICATE OF DEATH.

104

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Grantman

(Residence in Baltimore: No. 2029 Elsworth St St.; ..... yrs., 4 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 26, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 600 .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Grantman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Carrie Biggins

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. L. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Oct 26 1917, that I saw h in alive on October 26 1917, and that death occurred, on the date stated above, at 2'15 p m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal indigestion

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry H. Conrad M. D.

Oct 26, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2029 Elsworth St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 27, 1917

20-UNDERTAKER Henry Horch Son

ADDRESS 1301 E Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9535 — 152 — D 9535

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2799½ Alameda Av. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Evans

(Residence in Baltimore: No. 2799½ Alameda Av St.; ..... yrs., ... mos. ..... ds.) 16 hrs

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	X

6-DATE OF BIRTH, Oct 25, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 16 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Andrew J. Evans

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Margaret E Shawn

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew J. Evans

(Address) 2799½ Alameda Av

15-

Filed ....., 191.....

Registrar.

OCT 26 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26 191 , to Oct 26 191 , that I saw h[illegible] alive on Oct 26 191 , and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Delayed Labor

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Partial Asphyxia 16 hrs

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Oct 26, 191.) (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Oak Lawn	Oct 27th, 1917

20-UNDERTAKER	ADDRESS
Leo. G. Cook	North & Harford Aves.

D 9536

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9536

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1520 McHenry 19 ST.: WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam J. Stiner

(Residence in Baltimore: No. 1520 McHenry ST.: 62 yrs. 3 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: July 15th, 1855 (Month) (Day) (Year)

7-AGE: 62 yrs. 3 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Bal & O R R

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Abraham Stiner

11-BIRTHPLACE OF FATHER (State or country): Pa

12-MAIDEN NAME OF MOTHER: Lorina Bowersox

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura V. Stiner

(Address) 1520 McHenry St

15

Filed OCT 26 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 25th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1917, to Oct 25th 1917, that I saw h[illegible] alive on Oct 24, 1917, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis.
Initial Uremia

(Duration) Don't Know yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Faulkner M. D.

10.25, 1917 (Address) 29 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Oct 27, 191 7

20-UNDERTAKER: Joseph B. Cole ADDRESS: 1003 W Balto St

IMPORTANT. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 9537

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Hollins St. ST.: 18 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lottie A Sharpe.

(Residence in Baltimore: No. 1228 Hollins St. St.; yrs... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 12, 1877 (Month) (Day) (Year)

7-AGE, 65 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Carroll Meades

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Dora Brown

13-BIRTHPLACE OF MOTHER (State or Country), Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie L Barton

(Address) 203 S. Streeper St

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15 1917, to Oct. 26 1917, that I saw h-r alive on Oct. 26 1917, and that death occurred, on the date stated above, at 5.35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. — mos. — ds.

(Signed) Edgar E. Tavares M. D.

Oct 26, 1917. (Address) 1520 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State .. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ivy Hill Laurel Md. DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER William Cook ADDRESS 502 E North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9533

CERTIFICATE OF DEATH.

138 D 9533

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Garcia

(Residence in Baltimore: No. 519 S. Paca St.; 18 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 7, 1895
(Month) (Day) (Year)

7-AGE, 21 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: H. W.
(b) General nature of industry, business, or establishment in which employed (or employer): H. W. 037

9-BIRTHPLACE, (State or Country) Italy

PARENTS.

10-NAME OF FATHER, Salvador Galicia

11-BIRTHPLACE OF FATHER (State or Country) Italy.

12-MAIDEN NAME OF MOTHER Anna Palazzolo

13-BIRTHPLACE OF MOTHER (State or Country) Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C. Marcus

(Address) University Hospital

15-

Filed OCT 27 1917, 191... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-25 1917, to 10-26 1917, that I saw h[illegible] alive on 10-26 1917, and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Rheumatic Carditis (Pregnancy)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Marcus M. D.

10-26, 1917. (Address) University

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State ... yrs. — mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 519 S. Paca St.

19-PLACE OF BURIAL OR REMOVAL, Catholic Cem. DATE OF BURIAL, Oct. 28, 1917.

20-UNDERTAKER W. J. Gallagher ADDRESS 318 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9539

CERTIFICATE OF DEATH.

119

D 9539

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeth Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Woodland

(Residence in Baltimore: No. St. Elizabeth's Home St.; 4 yrs., 9 mos., 16 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	negress	Single

6-DATE OF BIRTH, January 9, 1913.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 9 mos. 16 da.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Woodland

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Alice Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Her mother Mary Mildred

(Address) St. Elizabeth's Home

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 0 1917, to October 24 1917, that I saw h[illegible] alive on October 24 1917, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Oct 25, 1917. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Oct 27th 1917.
20-UNDERTAKER	ADDRESS
George H. Williams	1231 Monument St

D 9540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9540

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarke Lynch

(Residence in Baltimore: No. 1437 Paxton St Phila Pa. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 25 (Month) (Day), 1889 (Year)

7-AGE, 28 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman.
(b) General nature of industry, business, or establishment in which employed (or employer): 073

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Lynch

11-BIRTHPLACE OF FATHER (State or Country), Delaware New Jersey

12-MAIDEN NAME OF MOTHER Mary Bradshaw

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Lynch

(Address) 1437 Paxton St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest. (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Pelvis Amputation
Leg. Inj. Contusions
Capillary Embolism
1 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) W. S. Thiley (Coroner) M. D.

Oct 27 1917 (Address) 1627 Bradbury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Single Cut Co Md — DATE OF BURIAL, Oct 27, 1917

20-UNDERTAKER: Wm. J. E. Dare Son — ADDRESS 1424 E Baltimore

Cause of death must be stated in every case. Any of the properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 104 D 9542

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patricia Mueller

(Residence in Baltimore: No. Quick Ave Gardenville St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 11, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Mathew Mueller

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Sweeney

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 25 1917, to Oct. 27 1917, that I saw h er alive on October 27 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

gastro-intestinal indigestion (acute)

(Duration) ....yrs. ....mos. 2 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 27, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Quick Ave Gardenville

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct. 28, 1917.

20-UNDERTAKER Eilly & Zeiler ADDRESS 403 S. Wolfe St.

D 9542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 9542

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelius C. Bowie Jr.

(Residence in Baltimore: No. 762 W. Lexington St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, August 8, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 17 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nothing
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Cecelius C. Bowie

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Anna. Spencer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Bowie

(Address) 762 W. Lexington St

15-

Filed....., 191.....

Registrar.

OCT 27 1917 ROBERT R. KRAUTER BURIAL PERMIT CLERK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scald 1 Burns about face, body and arms caused by fire of scalding hot water falling on him accidental. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. L. Driscoll M. D.
(Coroner.)

Oct 26, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	Oct. 29, 1917
20-UNDERTAKER W. M. Routson	ADDRESS 230 N. Greene

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9543

CERTIFICATE OF DEATH.

47 D 9543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 W. Saratoga ST.; 18 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Dunn

(Residence in Baltimore: No. 946 W. Saratoga St.; 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1871. (Year)

7-AGE,	If LESS than 1 day,
46 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Housework.

9-BIRTHPLACE, (State or Country), Newberry N.C.

PARENTS.

10-NAME OF FATHER, Israel Pettiford

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Dunn

(Address) 946 W. Saratoga St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 16 191 7, to Oct 24th 191 7, that I saw her alive on Oct 23 191 7, and that death occurred, on the date stated above, at 12:10 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) J. Guy Bowley M. D.

10/24, 1917. (Address) 436 Worth Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	10-28..., 1917.
20-UNDERTAKER Jno A. Soadwin	ADDRESS 142 Druid St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 D 9541

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 S. Paca ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Augaitis

(Residence in Baltimore: No. 530 S. Paca St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1867
(Month) (Day) (Year)

7-AGE, 50 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 006

9-BIRTHPLACE, (State or Country) Lithuania Russia

PARENTS.

10-NAME OF FATHER, Anthony Augaitis

11-BIRTHPLACE OF FATHER (State or Country) Lithuania Russia

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country) Lithuania Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michal Slavinsky

(Address) 532 S. Paca st

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 26 1917, that I saw him alive on Oct 26 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

(Signed) M. Gottenberger M. D.

....., 191... (Address) 622 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Oct 27 191...

20-UNDERTAKER Lukas Gyleliunas

ADDRESS 425 S. Paca St.

OCT 27 1917 ROBERT E. KRAUTZ

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9545

CERTIFICATE OF DEATH.

18 D 9545

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Philip R. Birt

(Residence in Baltimore: No. 611 S Lemmon Ave St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colrd

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. (Month) 20 (Day), 1884 (Year)

7-AGE, 33 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE. (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Philip R. Birt

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary R. Espey

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital

(Address) Grm & Lombard St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Vertebrae, caused by boxes falling on him while loading a wagon (accident)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) A. D. Lonsdale M. D. (Coroner.)

Oct 20, 1917. (Address) 512 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS). University Hospital

At place of death ....yrs....mos. 20 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, Oct. 22, 1917.

20-UNDERTAKER Wm. C. Black

ADDRESS 927 N Broadway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9546

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3444 Cedar Ave. St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Jane Smith

(Residence in Baltimore: No. 3444 Cedar Ave. St.; 43 yrs., —— mos. —— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, March 5, 1862
(Month) (Day) (Year)

7-AGE, 55 yrs. 7 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Pennsylvania

PARENTS.

10-NAME OF FATHER: Jeremiah Fisher

11-BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Sarah Ann Rose

13-BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Smith

(Address) 3444 Cedar Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1916, to October 24 1917, that I saw her alive on October 24 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Davis M. D.

Oct 25, 1917 (Address) 800 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery — DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER Benoweth & Son — ADDRESS 3617 Chestnut Ave.

OCT 27 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9547

CERTIFICATE OF DEATH.

91 D 9547

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 N Caroline ST.; 7 WARD) REGISTERED NO. C.....

2-FULL NAME Joseph Guthrie

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 713 N. Caroline St.: 65 yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 4th, 1852 (Month) (Day) (Year)

7-AGE, 65 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, J. S. Guthrie

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER Ann Marshall

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. S. Guthrie

(Address) 713 N. Caroline St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 25th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 21 1917, to October 25 1917, that I saw h.im alive on October 24 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Probable Brain Abscess

(from Suppurative Otitis)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Frank J. Lyd M. D.

October 25, 191.7. (Address) 1924 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Oct. 29, 191.7

20-UNDERTAKER Geo. M. Fring ADDRESS 811 W. Wolfe

Spec.—8-24-14—M. & T.—2000 Bks.

D 9548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9548

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Douglas O Fortunis

(Residence in Baltimore: No. 1325 Orchard St; 24 yrs., 8 mos 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Feb 24, 1893 (Month) (Day) (Year)

7-AGE, 24 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Asst. Helper
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, George H Kartanis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie E. Douglas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H Kartanis

(Address) 1325 N. Dona Hill

15- 1525

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1917, to Oct. 25 1917, that I saw h[illegible] alive on Oct. 25th 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 2d ds.

CONTRIBUTORY (Secondary) Peritonitis due to

resulting Appendix (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Grant M. G. Regan M. D.

Oct 25th, 1917. (Address) 1 E. Lexington Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Oct 27, 1917

20-UNDERTAKER Sam'l R. Case & Son — ADDRESS 1100 Mosher

5693

D 9549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 814 N. Paca St. 16 WARD)

REGISTERED No. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Butler Jr

(Residence in Baltimore: No. 814 N. Paca St.; 10 yrs., 3 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Single

6-DATE OF BIRTH, Dec 10, 1903
(Month) (Day) (Year)

7-AGE, 13 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles E. Butler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Butler

(Address) 814 N. Paca St.

15-

Filed ....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Operation

Cancer of Intestines

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(Duration) ....yrs. 4 mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 26, 191... (Address) 814 N. Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Oct 29, 1917
20-UNDERTAKER	ADDRESS
Jno. H. Otterson	1400 Madison

Important. See instructions on back of certificate.

OCT 27 1917 ROBERT E. KRAUTER Burial Permit Clerk

D 9550 (Affadavit pca)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 9550

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2229 Eutaw Place ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Morris

(Residence in Baltimore: No. 2229 Eutaw Place

St. 19 yrs., [redacted] mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ... Nov. ....., 1844
(Month) (Day) (Year)

7-AGE (71) 71 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION;
(a) Trade, profession, or particular kind of work..... Manufacturer 045
(b) General nature of industry, business, or establishment in which employed (or employer)..... of Bronze

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Morris

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Morris

(Address) 2229 Eutaw Place

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [redacted] (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said [redacted] (Inquest, autopsy or inquiry) find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicidal.

Gas Poisoning

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

(Address) 272 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bal. Hebrew Cem. DATE OF BURIAL, Oct 28th 1917

20-UNDERTAKER David Sondheim ADDRESS 118 W. Mt Royal Ave

L. S. P.

Important. See instructions on back of certificate.

Baltimore, Md.,

November 3rd, 1917.

HEALTH DEPARTMENT OF BALTIMORE CITY.

This is to certify that my father Mr. Edward Morris was born on November 25th, 1845, and at the time of his death was 71 years and 11 months old. The undertaker, Mr. David Sondheim, in asking this question made a mistake in informing you that he was 72 years and 11 months old.

Notary Public

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9551

CERTIFICATE OF DEATH.

19 D 9551

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jennings

(Residence in Baltimore: No. 602 Stumps Alley St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.)
Male	White	Widower

6-DATE OF BIRTH, Not known ....., 1 .....
(Month) (Day) (Year)

7-AGE, 60 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Steamfitter
(b) General nature of industry, business, or establishment in which employed (or employer) ..... " 074

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records Mercy Hosp

(Address) Calvert St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Oct 26 1917, that I saw him alive on Oct 26 1917 and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Not known
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward D. Smith M. D.

Oct 26, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. Life mos. ....ds.

Where was disease contracted, if not at place of death? Stumps Alley

Former or usual residence Stumps Alley

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	Oct 28 1917 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

OCT 27 1917 ROBERT E. LAMBERT REGISTRAR BUREAU OF VITAL STATISTICS

253

Spec.—8-24-14—M. & T.—2000 Bks.

D 9552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9552

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 N Calvert St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Knbs Smith

(Residence in Baltimore: No. 2510 N. Calvert St.; 75 yrs., 8 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, February 20, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John G. Knbs

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary A Cox

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Owen Hewitt

(Address) 2510 N Calvert St

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1917, to Oct. 26th 1917, that I saw her alive on Oct. 25th 1917, and that death occurred, on the date stated above, at 6 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. 7 ds.

(Signed) Thomas F. Steeman M. D.

Oct. 26, 1917. (Address) 1227 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, Oct 28, 1917

20-UNDERTAKER Stuart H Mowbray Co | ADDRESS 108 W Mt St

OCT 27 1917 ROBERT R. CRAIG Registrar of Vital Statistics

17

D 9553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9553

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 0n St. Cor. Cary & Baker St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Mumford

(Residence in Baltimore: No. 15-42 North Gaiss St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Single

6-DATE OF BIRTH, March — (Month) ..... (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Easton

(Address) 916 Aisquith

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral
Hemorrhage
1 hour
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Miller Noble M. D.
(Coroner.)
Oct 27, 1917. (Address) 1 W. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State 25 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 29 1917
20-UNDERTAKER	ADDRESS
David Easton	916 Eastern

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54 D 9551

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estes K. Ploss

(Residence in Baltimore: No. 1431 Hanover St.; 43 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feby 25th, 1874 (Month) (Day) (Year)

7-AGE, 43 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 030
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Machinist

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Ploss

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Laura J. Sheldon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret G. Ploss

(Address) 1431 Hanover St.

15-

OCT 27 1917

Filed....., 191.....

ROBERT H. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Oct 25 1917, that I saw h[illegible] alive on Oct 25 1917, and that death occurred, on the date stated above, at 11:45 m..

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Unrecognized

(Duration) 6 yrs. ....mos. ....ds.

(Signed) J. H. Baer M. D.

Oct 26, 1917. (Address) 1 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Oct 29th 1917.

20-UNDERTAKER E. Schlosman & Son ADDRESS 1039 Hanover St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9555

CERTIFICATE OF DEATH.

151

D 9555

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N. Milton ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellwood H. White

(Residence in Baltimore: No. 1028 N. Milton ave St.; yrs., 8 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, February (Month) 17 (Day), 1917 (Year)

7-AGE, ...yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Thomas H. White

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Elsie Carmine

13-BIRTHPLACE OF MOTHER (State or Country), Balto. md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. T. H. White

(Address) 1028 N. Milton ave

15-

Filed....., 191.....

OCT 27 1917 ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 26 (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 1917, to Oct 26 1917, that I saw h[e] alive on Oct 26 1917, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus.

due to inanition

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Extrasystoles

(Duration) yrs. mos. ds.

(Signed) Dr. [illegible] M. D.

Oct 27, 191. (Address) 2008 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 29, 191 7

20-UNDERTAKER Henry Horst Son

ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9556

CERTIFICATE OF DEATH.

REGISTERED No. C 5 67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home ST.; [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Rosskow

(Residence in Baltimore: No. 115 Aisquith Street St.; 36 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day), 1839 (Year)

7-AGE 77 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore

15-

Filed....., 191.....

Registrar.

OCT 23 1917 ROBERT R. KRAUTH Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1917, to Oct. 26 1917, that I saw him alive on Oct. 26 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

General Paresis

Aortic Stenosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs., mos. 14 ds.

(Signed) R. C. Michelson M. D.

Oct. 26, 1917. (Address) 1420 E. Balto. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Hebrew Rest

DATE OF BURIAL, 10/27, 1917

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9557 — B 9557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 Argyle Ave ST.; 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edward Williams

(Residence in Baltimore: No. 1429 Argyle Ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 27 (Month) (Day), 1900 (Year)

7-AGE, 17 yrs. 3 mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Printer 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Printer

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Charles E Williams

11-BIRTHPLACE OF FATHER (State or Country), Balt Cnty

12-MAIDEN NAME OF MOTHER Annie Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Love in Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Annie Wilson

(Address) 1429 Argyle Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1917, to Oct 25 1917, that I saw h[illegible] alive on Oct 25 1917, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

P
Pleurisy Exudative

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Lung

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

Oct 27, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Oct 28, 191.7.

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 506 East Pl

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9558

CERTIFICATE OF DEATH.

61 D 9558

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Bonnet St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Lehenn

(Residence in Baltimore: No. 827 N Carlton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, whte

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1... (Year)

7-AGE, 31 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... House
(b) General nature of industry, business, or establishment in which employed (or employer) ... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Ephraim Greenberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jenn

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Lehenn

(Address) 827 N Carlton

15-

OCT 28 1917

Filed ....., 191... ROBERT R. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

... Organic Heart Disease

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ... (Secondary)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)

Oct 28, 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Rest Friendship Cmt DATE OF BURIAL, Oct 28 1917

20-UNDERTAKER S. Levinson & Bro ADDRESS 1107 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9559

CERTIFICATE OF DEATH.

120 D 9559

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home + Infirmary St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ora C. Frames.

(Residence in Baltimore: No. 1921 St Paul St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 29th (Day), 1866 (Year)

7-AGE, 51 yrs. 4 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Oscar B. Cosby

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Tozer

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Fuller Frames

(Address) 1921 St Paul St

15-

Filed....., 191.....

Registrar.

OCT 28 1917 ROBERT P. KLAUTER Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Oct 27 1917, that I saw h[er] alive on Oct 27 1917, and that death occurred, on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonic Abscess

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Myocarditis + Pneumonia

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) H. H. Hausmann M. D.

Oct 27..., 191?. (Address) Church Home + Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 10 ds.

Where was disease contracted, if not at place of death? At above named residence

Former or usual residence 1921 St. Paul St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cemetery	Oct 29th, 1917.
20-UNDERTAKER	ADDRESS
George Schilling + Sons	1126 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

D 9560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9560

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gambrill

(Residence in Baltimore: No. White Marsh Md St.; 25 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Sept 6, 1892
(Month) (Day) (Year)

7-AGE, 25 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), White Marsh Md.

PARENTS.

10-NAME OF FATHER, Walter Gambrill

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Virginia Ayres

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter L. Gambrill

(Address).....

15-

OCT 28 1917 ROBERT P. BEAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Oct 26 1917, that I saw her alive on Oct 26 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation Apoplexy

over (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Wm Polk Littlefield M. D.

Oct 26, 1917. (Address) Franklin Sq Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 6 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence White Marsh Md

19-PLACE OF BURIAL OR REMOVAL, Camp Chapel Cemetery — DATE OF BURIAL, Oct 29th, 1917

20-UNDERTAKER Fredk Lassahn & Sons — ADDRESS Fullerton Md.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9561

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Brune ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Edward Brown

(Residence in Baltimore: No. 710 Brune St.; ....yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 23 (Day), 1849 (Year)

7-AGE.	If LESS than 1 day,
68 yrs. 4 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): O15

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lloyd Brown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Wilcox

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Brown

(Address) 2638 Hampden Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14 1917, to Oct 25 1917, that I saw h~~im~~ alive on Oct 25 1917, and that death occurred, on the date stated above, at 9.25 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Organic Heart disease

(Duration) 3 yrs. ....mos. ....ds.

(Signed) x Wm E. Brown M. D.

Oct 26, 1917. (Address) 1837 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Oct. 29, 1917.

20-UNDERTAKER	ADDRESS
Geo J Smith	Fayette 11

D 9562

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

D 9562

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2621 Edmondson Ave ST.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie E Williams

(Residence in Baltimore: No. 2621 Edmondson Ave St.: 33 yrs. 6 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: March 24, 1891 (Month) (Day) (Year)

7-AGE: 33 yrs. 6 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: E Williams

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Mabel J Kellers

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A B Leuthau

(Address) 2621 Edmondson Ave

15.

Filed OCT 28 1917, 191 ROBERT E. KRAUTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 26 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 3, 1917, to Oct 26 1917, that I saw h er alive on Oct 26, 1917, and that death occurred, on the date stated above, at 9-45 m.

The CAUSE OF DEATH* was as follows:

Pleuro-pneumonia

(Duration) ..... yrs. ..... mos. 23 ds

Contributory (SECONDARY) acute case of Tuberculosis

many months (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E R H Nutter M. D.

Oct 28, 1917 (Address) 1016 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pikesville Loudon County

DATE OF BURIAL: Oct 29, 1917

20-UNDERTAKER: Geo J. Smith

ADDRESS: 1000 N Eutaw St

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Unless physician signs, this certificate may not be properly classified.

D 9563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9563

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. S. Hospital St. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Campbell

(Residence in Baltimore: No. 145 Fortune St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, March (Month) ....., 1901 (Year)

7-AGE, 16 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): 023

9-BIRTHPLACE, (State or Country), Balt Va

PARENTS.

10-NAME OF FATHER, Harrison

11-BIRTHPLACE OF FATHER (State or Country), Campbell Co Va

12-MAIDEN NAME OF MOTHER Susan McJanson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lexington Dow

(Address) 645 Lemmon St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fracture of Skull Cerebral Hemorrhage

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Oct 26, 1917 (Address) 1301 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Northumberland Co Va — DATE OF BURIAL, Oct 28, 1917

20-UNDERTAKER James H. Dennis — ADDRESS 1303 Pennsylvania Ave

OCT 28 1917

Important. See instructions on back of certificate. Write very plainly. Use ink.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9561

CERTIFICATE OF DEATH.

92 D 9561

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 E 21 ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno George Jones

(Residence in Baltimore: No. 715 E 21st St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word) Married

6-DATE OF BIRTH, April (Month) 3 (Day) 1857 (Year)

7-AGE, 60 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer) Machinery

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Ro. Muir

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella R. Jones

(Address) 715 E 21st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 23, 1917, to Oct 27 1917, that I saw h im alive on Oct 27 1917, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Wm J Watson M. D.

Oct 28, 1917. (Address) 712 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Oct 30, 1917.

20-UNDERTAKER John O Mitchell

ADDRESS 120 W. Fayette

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9565

113 D 9565

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3010 E. Lanvale ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Paul Weller

(Residence in Baltimore: No. 3010 E. Lanvale Av St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: December (Month) 3 (Day) 1835 (Year)

7 AGE: 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Paul Weller

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kate Wolf

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Paul Weller

(Address) 3010 E. Lanvale

15 OCT 28 1917 ROBERT B. ... Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 26th (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1917, to Oct. 26th 1917, that I saw him alive on Oct 26th, 1917, and that death occurred, on the date stated above, at 3½ a m.
The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

about (Duration) 1 yrs. mos. ds

Contributory (SECONDARY) ascites

(Duration) yrs. 3 mos. ds.

(Signed) E. G. Shower M. D.

Oct 26th, 1917 (Address) 1224 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount DATE OF BURIAL: Oct 29, 1917

20 UNDERTAKER: Jos. Sherwood ADDRESS: 13 N. Eutaw

IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9566

CERTIFICATE OF DEATH.

+91

D 9566

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.;..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Florence Starr

(Residence in Baltimore: No. 4 Monroe (Johns Hopkins Hosp) St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, ... Jan. 6 ....., 1885
(Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Lucius Parker Starr

11-BIRTHPLACE OF FATHER (State or Country), Conn

12-MAIDEN NAME OF MOTHER, Harriet Wood

13-BIRTHPLACE OF MOTHER (State or Country), Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. Hand

(Address) John Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct. 28, ..., 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1917, to Oct 28 1917, that I saw h er alive on Oct 27 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

..... Pernicious Anemia .....

.....

.....

..... (Duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

Pneumonia (Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) A R Bloomfield M. D.

10-28, 191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 5 mos. — ds. In the State 41 yrs. 5 mos. ds.

Where was disease contracted, if not at place of death? in Brooklyn N.Y.

Former or usual residence Brooklyn, N.Y.

19-PLACE OF BURIAL OR REMOVAL, New York City, N.Y. DATE OF BURIAL, (10-28-, 191.7.

20-UNDERTAKER Elliott C Fuller ADDRESS 221 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9567

CERTIFICATE OF DEATH.

97 D 9567

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 E. Lanvale ST.; 9 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Krueger

(Residence in Baltimore: No. 1223 E. Lanvale St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married Single

6-DATE OF BIRTH, May 10 (Month) (Day), 1874 (Year)

7-AGE, 43 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis J. Kidd

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Rose Hamill

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George M. Krueger

(Address) 1223 E. Lanvale St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 - 1917, to Oct 25 1917, that I saw her alive on Oct 25 1917, and that death occurred, on the date stated above, at 11-15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Elmer Gill Hall M. D.

Oct 26, 1917 (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Oct 29, 191...

20-UNDERTAKER George J. Rueth

ADDRESS 1730 Hayford ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9568 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9568

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Forrest St ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A Mullen

(Residence in Baltimore: No. 815 Forrest St ST.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, January 27th, 1873
(Month) (Day) (Year)

7-AGE, 44 yrs. 10 mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Mullen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jemima Yeager

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. William Burke

(Address) 815 Forrest St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22nd 1917, to Oct 26th 1917, that I saw h— alive on Oct 26th 1917, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Chronic Interstitial
Nephritis

(Duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

Oct 26th 1917. (Address) 2537 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Oct. 29. 1917.

20-UNDERTAKER George J. Rentz

ADDRESS 1735 Harford Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+45 D 9569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary, St. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Gloscow

(Residence ~~in Baltimore~~: No. ~~Beach Bottom~~ Pa. In Hospital St.; ....yrs., mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH. April (Month) 17th (Day), 1839 (Year)

7-AGE, 78 yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ca

PARENTS.

10-NAME OF FATHER, John Gloscow

11-BIRTHPLACE OF FATHER (State or Country), Ca

12-MAIDEN NAME OF MOTHER Lydia Morgan

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Keely md

(Address) Union Prot Inf

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Oct 28 1917, that I saw him alive on Oct 28 1917, and that death occurred, on the date stated above, at 3 45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Operation Oct 17th

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Uremia

(Duration).....yrs.....mos.....ds.

(Signed) G. R. Mickley Attending M. D.

Oct 28, 1917. (Address) U.P.I.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 15 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Beach Bottom, Pa

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Delta Pa DATE OF BURIAL, Oct 28 1917

20-UNDERTAKER E & B Hartle ADDRESS 115 E Mrst St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9570 ✓ D 9570

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 W West St. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Simpkins

(Residence in Baltimore: No. 525 W. West St.: 0 yrs., 0 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, October 18, 1917.. (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 10 ds. If LESS than 1 day, .. hrs. or .. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Simpkins

11-BIRTHPLACE OF FATHER (State or Country), Annapolis, Md.

12-MAIDEN NAME OF MOTHER Susie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Annapolis Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Simpkins

(Address) 525 W. West St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25, 1917.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 18 1917, to October 25, 1917, that I saw her alive on October 25, 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar - pneumonia

(Duration) ..yrs. ..mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ..yrs. ..mos. ..ds.

(Signed) L. H. Douglass M. D.

Oct. 25, 191.7. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn St	Oct. 29, 191.7..
20-UNDERTAKER	ADDRESS
S. L. Brown's Son	1210 W. Mulb

Spec.—8-24-14—M. & T.—2000 blks.

D 2571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 2571

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Paca ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Lewis

(Residence in Baltimore: No. 511 N Paca St.; 45 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	M

6-DATE OF BIRTH, May (Month) 29 (Day), 1872 (Year)

7-AGE,	If LESS than 1 day,
45 yrs. 5 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter Oyster
(b) General nature of industry, business, or establishment in which employed (or employer): Chesapeake

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Lewis

(Address) 511 N. Paca St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 20th 1917, to Oct 27 1917, that I saw h[illegible] alive on Oct 27 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Tuberculosis

(Duration) yrs. mos. 1 ds.

(Signed) Frank Bergman M. D.

, 191... (Address) 322 N Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Brown	Oct 30, 1917.
20-UNDERTAKER	ADDRESS
W M Coulson	230 N Green

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9572

CERTIFICATE OF DEATH.

REGISTERED No. C 120 ✓ D 9572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N Bentelou · ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Boyd Jr.

(Residence in Baltimore: No. 1707 N Bentelou St ST.; 27 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1890 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. 2 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tobacco Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm A Boyd Sr.

11-BIRTHPLACE OF FATHER (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER Lydia Cummings

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida L. Boyd

(Address) 1707 N Bentelou St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 27 1917, that I saw h[e] alive on Oct 27 1917, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Uraemic Poison

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Endocarditis

(Duration) yrs. mos. ds.

(Signed) E. Lee Heuler M. D.

Oct 28, 1917. (Address) 2129 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, Oct 30, 1917.

20-UNDERTAKER Wm Cook — ADDRESS 502 E. Fayette.

Dr Heuler W. Main

D 9573 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 64

CITY OF BALTIMORE (No. 2028 Penna Av. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bass

(Residence in Baltimore: No. 2328 Penna Av. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Unknown, 1862
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: upholstering
(b) General nature of industry, business, or establishment in which employed (or employer): 085

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Deuchhausen

(Address) 2332 W. Lanvale

15-

Filed ..., 191... Registrar.

OCT 29 1917 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

1 week

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Grier M. D.
(Coroner.)

Oct 29, 1917. (Address) 719 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem.	Oct 29, 1917
20-UNDERTAKER Wm. Cook	ADDRESS 1032 Hull [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 0574 — 120 ✓ — D 0574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 866 W Baltimore St.; 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Morris

(Residence in Baltimore: No. 866 W. Baltimore St.; 58 yrs., — mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct. 22, 1859.
(Month) (Day) (Year)

7-AGE, 58 yrs. — mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Don't Know.

11-BIRTHPLACE OF FATHER (State or Country), do.

12-MAIDEN NAME OF MOTHER Don't Know.

13-BIRTHPLACE OF MOTHER (State or Country), do.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Stern

(Address) 866 W Baltimore

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5th 1917, to Oct. 27th 1917, that I saw her alive on Oct. 26th 1917, and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

1. Chronic Interstitial Nephritis (Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (Duration) — yrs. — mos. 7 ds.

(Signed) Edward E. Mackenzie M. D.

Oct. 28th, 1917. (Address) 1533 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 29, 1917
20-UNDERTAKER	ADDRESS
Harry A. Nitzke	1531 W. Lombard

Spec.—5-19-13—M. & T.—500 Bks.

D 9575

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 J

D 9575

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Calhoun ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME George W Crofoot

(Residence in Baltimore: No. 107 S Calhoun St.) Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, October (Month) 25 (Day), 1860 (Year)

7-AGE, 53 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Molder
(b) General nature of industry, business, or establishment in which employed (or employer)..... 047

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Damien Crofoot

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Evans

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Crofoot Jr

(Address) 107 S Calhoun St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Oct 24 1917, that I saw h in alive on Oct 24 1917, and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Valvular

(Duration) yrs. mos. ds.

(Signed) Joseph E Muse M. D.

Oct 26 1917 (Address) 520 Hudson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER Harry H. Witzke — ADDRESS 521 N London St

D 9576

HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH.

172 D 9576

REGISTERED No. C

CITY OF BALTIMORE (No. 443 W Pulton ST. WARD)

2-FULL NAME Wm A Bradley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 443 W Pulton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct 23 43
(Month) (Day) (Year)

7-AGE, 64 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Clerk in 009
(b) General nature of industry, business, or establishment in which employed (or employer) Candy factory

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W Bradley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Allen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bradley

(Address) 443 W Pulton

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Contusion of chest

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H Hanley (Coroner.) M. D.

Oct 26 191... (Address) N Pulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 443 W Pulton

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER Elliott & Fuller

ADDRESS 220 N Broadway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

9577 119 ✓ D 9577

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 S. Ellwood ave ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Travers

(Residence in Baltimore: No. 734 S. Ellwood ave St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct. 20, 1850. (Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Retired

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate T. Travers

(Address) 734 S. Ellwood ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 26th, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28th 1917, to Oct 26th 1917, that I saw him alive on Oct 26th 1917, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

.....

..... Acute Nephritis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. H. Bonsall M. D.

Oct 27th, 191 7. (Address) 734 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int. Laurel Cem

DATE OF BURIAL, Oct. 27, 191 7.

20-UNDERTAKER John A. Inman

ADDRESS 3005 E. Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D 9573

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N Curley St 6 ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mari Lagna

(Residence in Baltimore: No. 23 N. Curley St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1917 (Year)

7-AGE, ...yrs...mos...ds.

If LESS than 1 day, 2 hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Lagna

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Procacio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lagno

(Address) 23 N Curley

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Oct 27 1917, that I saw her alive on Oct 27 1917, and that death occurred, on the date stated above, at 10.45 P.M.

The CAUSE OF DEATH* was as follows:

Premature - Birth

(6 months)

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) John G. Guerin M.D.

Oct 29, 1917. (Address) Fairmount Ave & Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer — DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER John A Moran — ADDRESS Bond & Aisquith

D 9579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9579

CERTIFICATE OF DEATH.

REGISTERED No. C 175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital 22 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aloysius Purcell

(Residence in Baltimore: No. 525 S. Chas St.)

St., Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Sgl

6-DATE OF BIRTH, February 14, 1912
(Month) (Day) (Year)

7-AGE. 5 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Ed. Purcell

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Mary E. Summers

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Purcell

(Address) 525 S Chas St

15-

Filed....., 191.....

Registrar.

OCT 29 1917 ROBT. C. ANDREWS Registrar for the City of Baltimore

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries - accidental
Internal hemorrhage
due to Accidental
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(Duration) yrs. mos. ds.

(Signed) W. J. Ruby M. D.
(Coroner)
Oct 28, 1917 (Address) 16 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State Life yrs.....mos.....ds.

Where was disease contracted, if not at place of death? St Agnes Hospice Lexington St

Former or usual residence 525 S Chas St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Oct 31, 1917

20-UNDERTAKER F A Ferrance ADDRESS 703 E Monument

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9580 D 9580

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1228 Rankin Place ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda Gertrude Russell

(Residence in Baltimore: No. 1228 Rankin Place St.; 3 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept (Month) 28 (Day), 1850 (Year)

7-AGE, 67 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore County Md

PARENTS.

10-NAME OF FATHER, John H. Tracey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER Margaret Mealheney

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles J. Russell

(Address) 1228 Rankin Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25th 1917, to Oct 27th 1917, (that I saw her alive on Oct 26th 1917,) and that death occurred, on the date stated above, at 7.55 A.m.

The CAUSE OF DEATH* was as follows:

Edemic Intestinal Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. 2 mos. ds.

(Signed) H. L. H. [illegible] M. D.

Oct 27th, 1917. (Address) 110 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 1 mos. ds. In the State 67 yrs. 1 mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Same as above

19-PLACE OF BURIAL OR REMOVAL, Western Cemy

DATE OF BURIAL, Oct 30 1917

20-UNDERTAKER Jas Jacobs & Son

ADDRESS 217 S. Pace

D 0581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 ✓ D 0581

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 Augusta St., WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mendel Rosenko

(Residence in Baltimore: No. 109 Augusta, ; Ward.)

(If non-resident give STATE or COUNTRY instead of street and number.)

(If under 1 year, give AGE in hours or minutes.)

(If under 24 hours, give AGE in minutes.)

(If still born, say STILL BORN.)

(If unknown, say UNKNOWN.)

(If a minor, give NAME of father or mother.)

(If a married woman, give NAME of husband.)

(If a widow or widower, give NAME of last husband or wife.)

(Write plainly with pen and ink. Use no abbreviations.)

(Fill out all blanks with the answer "None" where there is no other answer.)

(Ditto; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widow

6-DATE OF BIRTH, ... (Month) ....., (Day) 1 (Year)

7-AGE, 108 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... A. Hofmann

(Address) 111 Augusta st

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

..... 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel | DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER May Levinson & Sons | ADDRESS 1107 E Baltimore

(See instructions on back of certificate.)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9582 — 81 — D 9582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 716 Columbia ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Stichtenoth

(Residence in Baltimore: No. 716 Columbia ave St.; 73 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, May 25, 1828 (Month) (Day) (Year)

7-AGE, 89 yrs. 5 mos. 2 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) in business

9-BIRTHPLACE, (State or Country), Wanfried, Germany

PARENTS.

10-NAME OF FATHER, Philip Stichtenoth

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Stichtenoth

(Address) 716 Columbia ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Oct 27 1917, that I saw h.. alive on Oct 25 1917, and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Uterine Tumor

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Morley Hoag M. D.

Oct 27, 191.7. (Address) 716 Columbia ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. — DATE OF BURIAL, Oct. 29th 1917.

20-UNDERTAKER Philip Seewald & Son — ADDRESS 1198 E. Eutaw St.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9583

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1379 W Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A Waters

(Residence in Baltimore: No. 1379 W Woodyear St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July (Month) 26 (Day), 1915 (Year)

7-AGE, 2 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John Waters

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ella Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Waters

(Address) 1379 Woodyear St.

15-

OCT 29 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 27 1917, that I saw h[illegible] alive on Oct 25 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Infantile Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 28, 1917. (Address) 2139 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER George H. Holland ADDRESS 137 Hermit Alley

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9581

CERTIFICATE OF DEATH.

2 D 9581

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1371 N. Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, Ania A. Hawkins

(Residence in Baltimore: No. 1371 N. Carey st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 4, 1890 (Month) (Day) (Year)

7-AGE, 27 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer) Fish market

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ania A. Hawkins

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lucy Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dianna Melock

(Address) 1371 N. Carey St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1917, to Oct 27 1917, that I saw h— alive on Oct. 26 1917, and that death occurred, on the date stated above, at 7-15 p.m.

The CAUSE OF DEATH* was as followa:

Pulmonary Tuberculosis

(Duration) ..... yrs. 3 mos. + ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm T. Wright M. D.

Oct 27, 1917. (Address) 1209 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 29, 191.

20-UNDERTAKER Clarence Wright

ADDRESS 1314 Mc ...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9585

CERTIFICATE OF DEATH.

170 D 9585

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2045 division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Harris.

(Residence in Baltimore: No. 2045 division St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Jan 15th (Month) ..... (Day) 185? (Year)

7-AGE, 60 yrs. 9 mos. 11 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter 070
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Fredericksburg Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lillie Harris

(Address) 2045 Division st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1917, to Oct. 26 1917, that I saw him alive on Oct. 25 1917, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage,

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) W. F. Carr M. D.

Oct. 27, 191 7 (Address) 515 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo H Holland

ADDRESS 631 E. 14, ave

Spec.—5-19-13—M. & T.—500 Bks.

D 9586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9586

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Linden ave ST.: Ut WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip H. Greene

(Residence in Baltimore: No. 1013 Linden ave St.: Like (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, July 4, 1878. (Month) (Day) (Year)

7-AGE, 39 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Public Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Edward Greene

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis E. Brookes

(Address) 755 Lanvale St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917.
Oct (Month) 27 (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23rd 1917, to Oct 26 1917, that I saw him alive on Oct 25 1917, and that death occurred, on the date stated above, at 5 a- m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Emmett Fargo M. D.

Oct 27th, 1917. (Address) 746 Dolphin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cem. DATE OF BURIAL, Oct 29, 1917.

20-UNDERTAKER Groh Hoffman ADDRESS 1631 Bank ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9587

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9587

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie A Gillet

(Residence in Baltimore: No. 2026 N Gay St.; 45 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, June (Month) Unknown (Day) 1872 (Year)

7-AGE, 45 yrs. 4 mos. (ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress 070
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Gilleland

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Hanson

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Gilleland

(Address) 2026 N. Gay st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27 (Month) (Day), 191.. (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 6 191 4, to Oct 27 191 7, that I saw h[illegible] alive on Oct 26 191 7, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

(Signed) Edward J [illegible] M. D.

10/27, 191.7 (Address) 413 N Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Bethlehem Cemetary	Oct 29, 191 7
20-UNDERTAKER	ADDRESS
Christian Miller	2334 Gay st

Spec.—8-24-14—M. & T.—2000 Bks.

9588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9588

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad H Bauer

(Residence in Baltimore: No. 1436 Hanover St.; 77 yrs. 9 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Jan. 12th, 1836
(Month) (Day) (Year)

7-AGE, 77 yrs. 9 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Bauer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Bauer

(Address) 1431 Hanover St.

15-

Filed....., 191....

Registrar.

OCT 29 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 28th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8 1917, to Oct. 28 1917, that I saw h.m. alive on Oct. 27 1917, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. F. Finkelstein M. D.

Oct. 28, 1917. (Address) 1429 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct. 30, 1917.

20-UNDERTAKER L. Schloman & Son ADDRESS 1039 Hanover St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9589

CERTIFICATE OF DEATH.

28 ✓ D 9589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N. Washington St.; 8 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Stoddard

(Residence in Baltimore: No. 1817 N. Washington St.; Life ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 8 (Day), 1893 (Year).

7-AGE,	If LESS than 1 day,
23 yrs. 7 mos. 19 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mason. 023
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Co.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Roland G. Stoddard

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hannah D Gage

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nellie A. Stoddard

(Address) 1817 N. Washington St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1915, to Oct 27 1917, that I saw h[im] alive on Oct 27 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jacob Fuchs M. D.

Oct 28, 1917. (Address) 1823 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Oct 30 1917

20-UNDERTAKER Karl J. Furnce — ADDRESS 1722 N. Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9590

CERTIFICATE OF DEATH.

79 V D 9590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Hollins ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Healy

(Residence in Baltimore: No. 921 Hollins St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widow

6-DATE OF BIRTH, Unknown (Month), (Day), 1880 (Year)

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas Lambe

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Julia Mulligan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Healy

(Address) 921 Hollins St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1917, to Oct 26 1917, that I saw h— alive on Oct 25 1917, and that death occurred, on the date stated above, at 10½ m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 1 ds.

(Signed) E. V. Cookerson M. D.

10/27/17, 191... (Address) 24 N Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct 30 1917

20-UNDERTAKER John Keown & Son ADDRESS 901 Hollins St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

91 D 0591

0591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Fawn ST.; 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Principio

(Residence in Baltimore: No. 1011 Fawn st. St.; ..... yrs., 11 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Singe

6-DATE OF BIRTH, Nov. (Month) 11 (Day), 1916 (Year)

7-AGE, ... yrs. 11 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Luciano Principio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Josefine Carcano

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorenzo Principio

(Address) 1011 Fawn st.

15-

Filed ....., 191.... OCT 29 1917 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 28th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 191.., to Oct 191 7, that I saw h.. alive on Oct 29 191 7, and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Hoffman M. D.

Oct 29, 191.. (Address) 1685 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent — DATE OF BURIAL, Oct. 29, 1917

20-UNDERTAKER Rudell Siffert Son — ADDRESS 332 S. Bond st.

D 9592

HEALTH DEPARTMENT—CITY OF BALTIMORE

159

D 9592

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1445 Towson St. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel M.Taylor.

(Residence in Baltimore: No. 1445 Towson St. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, July. 29th. 1867., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
50 yrs. 2 mos. 28 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron worker.
(b) General nature of industry, business, or establishment in which employed (or employer): 079

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Samuel Taylor.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Sarah Henry.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ruth Aprill. (sister)

(Address) 1445 Towson St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the Head.
Suicide.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M Reinhardt M. D. (Coroner)

Oct, 28, 1917 (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Oct 30, 1917
20-UNDERTAKER	ADDRESS
Mrs J. E. Evans	1428 S Charles St

Spec.—8-24-14—M. & T.—2000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 9. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Hoffman

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, 10 (Month) 27 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
...yrs...mos...ds.	9 hrs. or...mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frauen Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Phila Pa

12-MAIDEN NAME OF MOTHER Mary Conway

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-27 1917, to 10-28 1917, that I saw h... alive on 10-27 1917, and that death occurred, on the date stated above, at ... a. m.

The CAUSE OF DEATH* was as follows:

Premature birth - 8 mo.

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Born at home - mother

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) ..... M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	Oct 29 1917
20-UNDERTAKER Commissioner Health	ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 38 Wards WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul B. Kreuder

(Residence in Baltimore: No. University Hospital St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Mal

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec Seven (Month) (Day), 1859 (Year)

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Richard P. Kreuder

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER L. Manning

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Nolan

(Address) University Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10 21 1917, to 10 28 1917, that I saw h[illegible] alive on 10 28 1917, and that death occurred, on the date stated above, at 6 50 m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(Duration) 3 yrs. mos. ds.

(Signed) [illegible] M. D.

10/28, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York Niagara Falls

19-PLACE OF BURIAL OR REMOVAL, Watertoo New York — DATE OF BURIAL, Oct 29, 1917

20-UNDERTAKER Chas J Ornsdorf & Son — ADDRESS 118 W Mt Royal ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 North Ave ST.; 4 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Romine Pulley

(Residence in Baltimore: No. 303 North Ave St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
[illegible]	[illegible]	

6-DATE OF BIRTH, August (Month) 1917 (Day), 1 (Year)

7-AGE, 2 months 27 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, William H Pulley

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Nellie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) William Pulley

(Address) 303 North Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 27 1917, that I saw h[illegible] alive on Oct 27 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) 4 yrs. 2 mos. ds.

(Signed) [illegible] M. D.

Oct 27, 191[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	....., 191..
20-UNDERTAKER	ADDRESS
[illegible]	[illegible]

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9596

Registered No. C

1 PLACE OF DEATH

City of Baltimore (No. 817 N Madeira Street St. 7 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hilda Bertha Reiche (Reiche)

Residence in Baltimore: No. 817 N Madeira Street St.

21 yrs. 1 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Please use the word): Single

6 DATE OF BIRTH: 12 September (Month) (Day), 1896 (Year)

7 AGE: 21 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Collar Baster
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing (Gents)

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Henry Reiche

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Debus

13 BIRTHPLACE OF MOTHER (State or country): Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Reiche

(Address) 817 N. Madeira

15

Filed . 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 25th, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20th, 1917, to Oct. 25 1917, that I saw h or alive on October 25, 1917, and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar
Pneumonia (Double) Left side front
Right side second

(Duration) — yrs. — mos. 3 ds.

Contributory (SECONDARY) Acute Parenchymatous Nephritis

Feb 5/17 (Duration) yrs. 8 mos. — ds.

(Signed) Alpid White Head M. D.

, 191 (Address) 1213 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore — DATE OF BURIAL: Oct 29, 1917

20 UNDERTAKER: Philip Henry — ADDRESS: 201 Collins

IS VERY IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9507

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST.) WARD)

REGISTERED No. C 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margarite Jenkins

(Residence in Baltimore: No. 423 N. High St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, May 8, 1834
(Month) (Day) (Year)

7-AGE, 83 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Thomas Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Rider

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. L. Armiger

(Address) 505 Orkney Road Govans

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Oct 25 1917, that I saw h.. alive on Oct 21 1917, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Accidental Fall
Fracture (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(Durntion) yrs. 1 mos. 2 ds.

(Signed) Chas. W. Voss M. D.

Oct 26, 1917 (Address) 1515 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 423 N. High St.

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct 30, 1917

20-UNDERTAKER John O. Mitchell ADDRESS 1021 Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH St. Vincents Inf. Asylum REGISTERED NO. C

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline E. Thomas

(Residence in Baltimore: No. 1401 Division St.; yrs. 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 7th, 1917. (Month) (Day) (Year)

7-AGE, yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Harry W. Thomas

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Caroline E. Wenzel Deceased.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wenzel

(Address) 1626 E. Oliver

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 28, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Oct 28 1917, that I saw her alive on Oct 28 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) E. A. C. Parker M. D.

Oct 29, 1917. (Address) 1114 Hartford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the State yrs. 3 mos. 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1626 E. Chase St.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Oct 30, 1917

20-UNDERTAKER J. Hayes ADDRESS 514 Wilson

Spec.—5-19-13—M. & T.—500 Bks.

D 9599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N Fremont Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

2-FULL NAME James L. Knights

(Residence in Baltimore; No. 507 N. Fremont Ave St.; 21 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September (Month) (Day), 1867 (Year)

7-AGE, About 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Painter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, John T. Knights

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Jane Connelly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Kennedy

(Address) 905 N. Fremont Ave

15-

Filed ..... 191....

Registrar.

OCT 29 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 28th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26th, 1917, to Oct 28th, 1917, that I saw him alive on Oct 28, 1917, and that death occurred, on the date stated above, at 1145 a.m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. ds.

(Signed) Ellen McLean M. D.

Oct 29th 1917. (Address) 1100 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER Graham & Weeks ADDRESS 77-310 Hall

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Eastern Ave (ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katharine Koenig.

(Residence in Baltimore: No. 2817 Eastern Ave.

St.: 25 yrs. 6 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. April 7 th (Month) (Day), 1892 (Year)

7-AGE. 25 yrs. 6 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). Invalid

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George Koenig.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary A. Fleischmann

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mary A. Fleischman.

(Address). 28 E. Eastern Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from October, 191 7, to (191 ,

that I saw h alive on (191 ,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Cystitis Chronic

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) 16 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

10/27, 1917. (Address) 2737 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or osoal residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer.

DATE OF BURIAL, Oct 30 ....., 191...

20-UNDERTAKER Lilly & Feiler

ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna E Johnson

(Residence in Baltimore: No. 1514 N Eutaw St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. January 3, 1917 (Month) (Day) (Year)

7-AGE. ....yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles H Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rose Ickert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Asst Supt

(Address) Johns Hopkins Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 191 , to Oct 29 191 , that I saw h alive on Oct 29 191 , and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

1. Pyro-tuberculosis, acute

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 29, 191 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1514 N Eutaw St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER William Cook ADDRESS 802 E North

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeths Home ST.; 49 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Knight.

(Residence in Baltimore: No. St. Elizabeth's Home St.; 1 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male female

4-COLOR OR RACE, negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Don't know (Month) ....., 1 (Day) (Year)

7-AGE, Probable ....1....yrs....7....mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Committed to institution by Judge Williams

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 27 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to October 27 1917, that I saw him alive on October 26 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

.....Pneumonia.....

..... (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (Duration)....yrs....mos. 14 ds.

(Signed) Frank J. Cook M. D.

....., 191... (Address) 1327 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT 29 1917
20-UNDERTAKER Commissioner of Health	ADDRESS

Per Wm F Westcott

D 9603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9603

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1444 N Mount St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Smith

(Residence in Baltimore: No. 1444 N Mount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... Dec. 5, 1916
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
..... 2 yrs. 10 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lucy Lawson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mother

(Address) 1444 N Mount

15-

OCT 29 1917

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct 27, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... Autopsy
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)

.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....a. Convulsions

..... Marasmus

..... (Duration) ....yrs. 1 ....mos.....ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ....yrs. 4 mos.....ds.

(Signed)..... M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	OCT. 29. 1917

20-UNDERTAKER	ADDRESS
Commissioner Health.	

Per. Wm. H. WOODALL.

Spec.—8-24-14—M. & T.—2000 lks.

D 2601.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

157 D 2601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.) (or WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Ottenheimer

(Residence in Baltimore: No. 720 Chauncy ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) X

6-DATE OF BIRTH. Oct 24, 1917
(Month) (Day) (Year)

7-AGE. X yrs. X mos. X ds.

If LESS than 1 day, 2 hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Leo Ottenheimer

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Vera Stern

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Ottenheimer

(Address) 920 Chauncy Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 191 7, to Oct 29 191 7, that I saw her alive on Oct 27 191 7, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) 2 hrs

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward W. Smith M. D.

Oct 28 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 2 hrs yrs mos. ds.

Where was disease contracted, if not at place of death? none

Former or usual residence none

19-PLACE OF BURIAL OR REMOVAL, Balt Hebrew DATE OF BURIAL, Oct 30, 1917.

20-UNDERTAKER David Fordham ADDRESS 1117 Eden

D 9605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fayerweather Hotel Kennedy St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S. Woodward

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ..., 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Alabama

PARENTS.

10-NAME OF FATHER, S. Woodward

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ruth Dowell

13-BIRTHPLACE OF MOTHER (State or Country), Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. Woodward

(Address) Hotel Kennedy

15-

Filed....., 191.....
Registrar.

OCT 29 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull and Shock

Caused by running from burning Hotel Resulted in Death Instantly

(Duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) A. J. Tilley M. D.
(Coroner.)

Oct 29, 1917 (Address) 16 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Providence R. I.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Providence R I	Oct 29, 1917

20-UNDERTAKER	ADDRESS
H E Hughes	17 S Broadway

Spec—5-19-13—M. & T.—500 Blks

D 9606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9606

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 E Fort Ave St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Meuke

(Residence in Baltimore: No. 516 E Fort ave St.; yrs... mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec. (Month) 7 (Day), 1845 (Year)

7-AGE, 71 yrs. 10 mos. 20 ds.

If LESS than 1 day. ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wm. Schuler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Smith

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Meuke

(Address) 516 E Fort ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6, 5 1917, to 10/27 1917, that I saw her alive on 10/27 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Dis (Sudden)

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(Duration) 5 yrs. mos. ds.

(Signed) L. D. Bullington M. D.

10/27, 191.7 (Address) 102 E Fort ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Oct. 30 1917

20-UNDERTAKER E J Denning — ADDRESS 1460 Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9607

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. On way to Franklin Square Hosp. St., WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Lews.

(Residence in Baltimore: No. 19 N. Ellwood Ave St.; 34 yrs., 11 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, November 13, 1882
(Month) (Day) (Year)

7-AGE, 34 yrs. 11 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter in Cafe
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Albert Lews

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Albertina Klavetter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albertina Lews
(Address) 19 N. Ellwood Ave

15-
OCT 29 1917
Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1917, to October 1917, that I saw h alive on October 29 1917, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Brights Disease

(Duration) 1 yrs. 6 mos. ds.

(Signed) Maxwell L. Mazer M. D.

10/29, 1917 (Address) 1079 E. Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Oct. 31, 1917

20-UNDERTAKER Jos Cook — ADDRESS 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X14 D 9608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 11 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Patterson

(Residence in Baltimore: No. 721 E. Preston St. St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 4, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)..... Real Estate 086

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wm H. Patterson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Virginia Williams

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Record Mercy Hosp.

(Address)..... Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Oct 28 1917, that I saw him alive on Oct 28 1917, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) Grant Term yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward L. Duvall M. D.

Oct. 28, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State ....yrs. 3 mos. ....ds.

Where was disease contracted, if not at place of death? Dont know probably Virginia

Former or usual residence 721 E. Preston (for 3 mo.)

19-PLACE OF BURIAL OR REMOVAL, Culpeper Va | DATE OF BURIAL, ..., 191...

20-UNDERTAKER Joseph Lenhart | ADDRESS 1 [illegible]

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9609

CERTIFICATE OF DEATH.

28

D 9609

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Collington Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Chenoweth

(Residence in Baltimore: No. 514 Collington ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Aug 29, 1897 (Month) (Day) (Year)

7-AGE. 20 yrs. 1 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Andrew Chenoweth

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Haas

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Hunter

(Address) 514 N. Collington

15- WE

OCT 29 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1917, to Oct 27 1917, that I saw her alive on Oct 27 1917, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Fatal

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Walter W. White M.D.

Oct. 29, 1917. (Address) 11 E. Read

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Oct. 30, 1917

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Broadway

Spec.—8-24-14—M. & T.—[illegible]00 Blks.

D 9610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 D 9610

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) ST.; 3 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Wolf

(Residence in Baltimore: No. 222 Spring St.; 70 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) 1842 (Year)

7-AGE. 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Unknown
(b) General nature of industry, business, or establishment in which employed (or employer). 087

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

Registrar.

OCT 29 1917 ROBERT T. KRAUTHS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-3 1917, to 10-24 1917, that I saw h[illegible] alive on 10-24 1917, and that death occurred, on the date stated above, at 4.55 p.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia 10 d

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louis L. Jacobs M. D.

10-29, 1917. (Address) H. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 26 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 320 S. Spring St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Woodlawn Rd. DATE OF BURIAL, 10/30/1917

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

D 9611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

D 9611

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1815 Eutaw St. 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Litchfield

(Residence in Baltimore: No. 64 N Gay St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Paper Seller,
(b) General nature of industry, business, or establishment in which employed (or employer).....

642

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Lorenzo Litchfield.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Cynthia Poole

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Litchfield,

(Address) 1126 Harford Ave

15- OCT 29 1917

Filed....., 191.....

ROBERT B. KRAUSE
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Oct 29, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laudon Pk.	Oct 30, 1917
20-UNDERTAKER	**ADDRESS**
Leo. G. Cook	North & Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9612

CERTIFICATE OF DEATH.

D 9612

REGISTERED NO. C 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Mc Cracken

(Residence in Baltimore: No. 407 N. Luzerne St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan. 5, 1903 (Month) (Day) (Year)

7-AGE, 14 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, John Mc Cracken

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Rheba Whittaker

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mc Cracken

(Address) 407 N. Luzerne St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27 1917, to Oct 29 1917, that I saw h[illegible] alive on Oct. 29 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cystic Goitre (4 mos)
Diabetes Mellitus
(Duration) yrs. 3-4 mos. ds.
CONTRIBUTORY (Secondary) Diabetic Coma
(Duration) 1 yrs. mos. 1 ds.

(Signed) Israel Feinberg M. D.
Oct 29, 1917 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? residence

Former or usual residence 407 N Luzerne St.

19-PLACE OF BURIAL OR REMOVAL, Ft Philadelphia — DATE OF BURIAL, Oct 30, 1917.

20-UNDERTAKER Charles E Frank — ADDRESS 802 Madison Ave

D 9613

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2417 Hoadbrook, St. 13 Ward)

REGISTERED No. C 120 D 9613

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Baker

(Residence in Baltimore: No. 2417 Hoadbrook St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Fem	White	Widow

6 DATE OF BIRTH Sept 16, 1863 (Month) (Day) (Year)

7 AGE 54 yrs. 1 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ---

9 BIRTHPLACE (State or country) Harwood Co. Md.

PARENTS

10 NAME OF FATHER Wm Browning

11 BIRTHPLACE OF FATHER (State or country) Harwood Co Md

12 MAIDEN NAME OF MOTHER Mary Laurence

13 BIRTHPLACE OF MOTHER (State or country) Harwood Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel ...

(Address) 2417 Hoadbrook

15. Filed ..., 191... REGISTRAR

OCT 29 1917 ROBERT R. CHAUTES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct., 1915, to Oct., 1917, that I saw h[er] alive on Oct. 27, 1917, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - nephritis apoplexy.

(Duration) 2 yrs. ... mos. ... ds

Contributory (SECONDARY) Oedema of lungs

(Duration) ... yrs. ... mos. 1 ds.

(Signed) J. Frederick Leib M. D.

Oct 29, 1917 (Address) 2040 Eutaw place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park — DATE OF BURIAL Oct 30, 1917

20 UNDERTAKER Leo J Smith — ADDRESS 1000 Fayette St

IS VERY IMPORTANT. See instructions on back of certificate. ... may be properly classified. Exact statement of OCCUPATION

Spec.—5-19-13—M. & T.—500 Bks.

D 9611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9611

CERTIFICATE OF DEATH.

42

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 N. Carrollton Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa P. Eaves

(Residence in Baltimore: No. 331 N. Carrollton Ave St.: ...yrs., ...mos. ...ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widow

6-DATE OF BIRTH, August 15th, 1855
(Month) (Day) (Year)

7-AGE, 62 yrs. 2 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Home work

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not obtainable

11-BIRTHPLACE OF FATHER (State or Country), not obtainable

12-MAIDEN NAME OF MOTHER, not obtainable

13-BIRTHPLACE OF MOTHER (State or Country), not obtainable

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Eaves

(Address) 331 N. Carrollton Ave

15-

OCT 29 1917 ROBERT B. KRAUTER Registrar.

Filed....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1916, to Oct 28th 1917, that I saw her alive on Oct 28th 1917, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Coma

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

Duration yrs. mos. ds.

(Signed) Edward Eaves M. D.

Oct 29, 191.. (Address) 331 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Oct 31, 191.7

20-UNDERTAKER Geo. J. Smith ADDRESS 1300 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9815

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Whitley

(Residence in Baltimore: No. 2319 Jefferson St.; 44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, July 2, (Month) (Day) 1873 (Year)

7-AGE, 44 yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 109
(b) General nature of industry, business, or establishment in which employed (or employer): Wilcox Coal Yard

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Whitley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emelia E. Tapley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie W. Whitley

(Address) 1738 Ashland Ave

15-

Filed ....., 191.....

Registrar.

OCT 29 1917 Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Oct 28 1917, that I saw him alive on Oct 28 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Mitral lesion (regurgitant) and Pulmonary Congestion

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Adolph C. Eisenbeis M. D.

Oct 29 1917. (Address) 2241 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 31 17, 191...

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson St

D 9616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9616

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 802 S Robinson ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frederick Litz

(Residence in Baltimore: No. 802 S. Robinson St.: yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 19 (Day), 1896 (Year)

7-AGE, 21 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ferdinand Litz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia Bdell

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Strickfuss

(Address) 802 S. Robinson st

15-

Filed....., 191.... Registrar.

OCT 29 1917 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Henry Ryan Asst Co. (Coroner.) M. D.

Oct 29, 1917. (Address) 16 10 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER Christian Miller — ADDRESS 2334 Jefferson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9617

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Presbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Bruce

(Residence in Baltimore: No. 1608 Presbury St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 24, 1877 (Month) (Day) (Year)

7-AGE, 39 yrs. 11 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Thomas Bishop

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Cassandra Jones

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bruce

(Address) 1608 Presbury St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14 1917, to Oct 27 1917, that I saw h[illegible] alive on Oct 26 1917, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ?? ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 8 mos. ds.

(Signed) Wm J Sullivan M. D.

Oct 29, 1917. (Address) 1304 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn — DATE OF BURIAL, Oct. 30, 1917.

20-UNDERTAKER John H Crow — ADDRESS 533 N. Gilmor

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9613 D 9613

CERTIFICATE OF DEATH.

28 ✓

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 115 Peach al ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert L. Connolly

(Residence in Baltimore: No. 115 Peach al St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, June (Month) 5 (Day) 1882 (Year)

7-AGE, 35 yrs. 4 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm N. Connolly

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Cropper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm N. Connolly

(Address) 115 Peach al.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1917, to Oct 27 1917, that I saw him alive on Oct 27 1917, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

6
Pulmonary tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 27 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem.	Oct 30, 1917
20-UNDERTAKER	ADDRESS
M. A. Flynn	1422 Light

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9619

CERTIFICATE OF DEATH.

120

D 9619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 E. 23rd do ST.; 17 WARD) REGISTERED NO. C

2-FULL NAME George Edwin Entwisle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 213-23rd St. 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 18, 1845 (Month) (Day) (Year)

7-AGE, 71 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 086

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Reporter

9-BIRTHPLACE, (State or Country), Alexandria Va.

PARENTS.

10-NAME OF FATHER, Wm B. Entwisle

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary E. Lockwood

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta Entwisle

(Address) 213 E. 23rd St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) / 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/1 1917, to 10/28 1917, that I saw him alive on 10/28 1917, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis

Uremic Intoxication

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Dementia (Senile)

Exhaustion (Duration).....yrs.....mos.....ds.

(Signed) W. Stanley Grant M. D.

10/29, 1917 (Address) 2906 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Rd

DATE OF BURIAL, Oct. 30, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. North

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9620

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 810 E 22nd St. Ward 9)

2-FULL NAME Maria Eliza Snyder

(Residence in Baltimore: No. 810 E 22nd St. St.: — yrs. — mos. — ds.)

Registered No. C 1320 D 9620

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

is very important. See instructions on back of certificate. Exact statement of OCCUPATION is necessary, as many occupations are properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July 8, 1843 (Month) (Day) (Year)

7-AGE: 74 yrs. 3 mos. 21 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Phila Penn

PARENTS

10-NAME OF FATHER: William J Thomason

11-BIRTHPLACE OF FATHER (State or country): Penn

12-MAIDEN NAME OF MOTHER: Jane W Stout

13-BIRTHPLACE OF MOTHER (State or country): Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence M Sellars

(Address) 810 E 22nd St

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 29 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1917, to Oct 29 1917, that I saw h e alive on Oct 29, 1917, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(Duration) 1 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Francis P McCarran M. D.

Oct 29, 1917 (Address) 416 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Phila. Pa

DATE OF BURIAL: Oct 31, 1917

20-UNDERTAKER: Wm Cook

ADDRESS: 1012 E North

Via P.R.R. c/o Florence M Sellars

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9621 ✓ D 9621

CERTIFICATE OF DEATH.

REGISTERED No. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N Patterson Park Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Slade

(Residence in Baltimore: No. 1801 N Patterson Park ave St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept (Month) 16 (Day) 1845 (Year)

7-AGE, 72 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N Y

PARENTS.

10-NAME OF FATHER, Wm Gale

11-BIRTHPLACE OF FATHER (State or Country). N Y

12-MAIDEN NAME OF MOTHER Eunice Brush

13-BIRTHPLACE OF MOTHER (State or Country), Conn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Rossett

(Address) 1442 N Gay St

15-

Filed....., 191.....

Registrar.

OCT 30 1917 HARRY C. ANDREWS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Oct 27 1917, that I saw her alive on Oct 27 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Pearce M. D.

Oct 28, 1917 (Address) 5 S. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL, Oct 30, 1917

20-UNDERTAKER Geo Rossett ADDRESS 1442 N Gay St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D 9622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 N. Calvert ST.; 12th WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Absalom Sparks

(Residence in Baltimore: No. 2322 N. Calvert St.; 9 yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, December (Month) 15 (Day), 1837 (Year)

7-AGE, 79 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Coal.

9-BIRTHPLACE, (State or Country), Kent County, Maryland

PARENTS.

10-NAME OF FATHER, Absalom M. Sparks

11-BIRTHPLACE OF FATHER (State or Country), Queen Annes Co. Md.

12-MAIDEN NAME OF MOTHER Mary L. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co., Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence J. Kennard

(Address) 2322 N. Calvert St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1917, to Oct 29 1917, that I saw h... alive on Oct 29th 1917, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Infirmities of Age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Talbott M. D.

Oct. 29, 1917. (Address) 2413 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cohesterton Md. DATE OF BURIAL, Oct 31st, 1917

20-UNDERTAKER Henry W. Jenkins & Son ADDRESS McCulloh & Eutaw Sts

D 9623

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

D 9623

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 104 N. Pofspleton ST. 18 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary R. Davis

(Residence in Baltimore: No. 104 N. Pofspleton St.: 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: October 10th 1853 (Month) (Day) (Year)

7-AGE: 64 yrs. — mos. 19 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: Philip Weber

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary Lampe

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Harnett Mamel

Daughter (Address) 102 N. Pofspleton St.

15-

Filed ..... , 191 .....

OCT 30 1917 BARRY C. AMBLER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 29th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1917, to Oct 29th 1917, that I saw her alive on Oct 28th 1917, and that death occurred, on the date stated above, at 6 4th m.

The CAUSE OF DEATH* was as follows:

Albuminuria

Several Years (Duration) yrs. mos. ds

Contributory (SECONDARY) Uraemic Toxaemia

2 weeks (Duration) yrs mos. ds.

(Signed) David L. Reinhart, M. D.

Oct-29, 1917 (Address) N. Patterson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: 10-31, 1917

20-UNDERTAKER: H. Brennan Son

ADDRESS 517 N. Schroeder St

is very important. See instructions on back of certificate. Exact statement of OCCUPATION

17 9621
sfc
c/

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9621

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 507 N. Bruce ST. 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Thomas

(Residence in Baltimore: No. 507 N. Bruce St.) yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colo	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1861 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country) ~~Balto~~ Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife

(Address) 507 N. Bruce

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cystic Ovary (Cancer)
Died Suddenly
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct 29, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 30, 1917
20-UNDERTAKER Hilbert Bros.	ADDRESS 114 N. Schroeder St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓ D 9625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Druid Hill Ave ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Mason

(Residence in Baltimore: No. 1009 Druid Hill Ave St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1865 (Year)

7-AGE, 52 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): store 086

9-BIRTHPLACE, (State or Country). md

PARENTS.

10-NAME OF FATHER, Braxmason

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Jane Lewis

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vera Mason

(Address) 1009 Druid Hill Ave

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 191 , to Oct 26 191 , that I saw h[illegible] alive on Oct 26 191 , and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL. Oct 30, 1917

20-UNDERTAKER Geo A Holland

ADDRESS 1631 Pt Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D 9626

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 W Fairmount ave. St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Harris

(Residence in Baltimore: No. 1530 W Fairmount ave St.; 0 yrs., 0 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, October 27, 1917
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 2 ds. If LESS than 1 day, 2 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Harris

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Harris

(Address) 1530 W Fairmount Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 27 1917, to October 29 1917, that I saw her alive on October 29, 1917, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

The cause of death undetermined

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. H. Douglass M. D.

Oct 29, 191 7. (Address) Maryland Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pt Lookout Cemetery

DATE OF BURIAL, Oct 30, 191...

20-UNDERTAKER Geo H Hooper

ADDRESS 410 Mosher St

OCT 30 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 9627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9627

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerald Elffrich

(Residence in Baltimore: No. Steam Ship Martinsdijk - Balto Harbor St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 19, 1900
(Month) (Day) (Year)

7-AGE, 17 yrs. 5 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(h) General nature of industry, business, or establishment in which employed (or employer) Sailor

9-BIRTHPLACE, (State or Country), Holland

PARENTS.

10-NAME OF FATHER, Gerald Elffrich

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Holland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Secretary Stmp

(Address) Balto St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Oct 29 1917, that I saw him alive on Oct 29 1917, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

about

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A. Smith M. D.

Oct 29, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 19 ds. In the State about 17 yrs. ..... ds.

Where was disease contracted, if not at place of death? On Board Steam Ship

Former or usual residence Holland

19-PLACE OF BURIAL OR REMOVAL, Schwartz Cemetery — DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER Robt J Turner — ADDRESS 472 W Broad

MERCY HOSPITAL
CONDUCTED BY THE SISTERS OF MERCY
CALVERT & SARATOGA STS
BALTIMORE, MD

Baltimore, Md. Nov. 2, 1917.

Registrar of Vital Statistics,
Dept. of Health ,
Balto., Md.

Dear Sir:-

On Oct. 29th 1917-I issued a death cerfificate placing thereon the name of the deceased as Gerald Elffrich, who died at Mercy Hospital on Oct. 29th 1917- The name has been incorrectly spelled, and should be Gerardus Elfferich. Kindly change this record accordingly.

The residence is given on said certificate as 'S Marrtensdyk . The spelling of this is incorrect, and should be Maartensdyk .

Kindly make this correction.

Signed: Edward C Smith M.D.

EPS/E W.

Subscribed and sworn to before me this 2nd day of Nov 1917.
Geo E Robinson
Notary Public

Spec.—8-24-14—M. & T.—2000 Bks.

9623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D 9623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Milton Ave ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George [redacted]dam (Adam)

(Residence in Baltimore: No. 1413 N. Milton Ave St.; 28 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	White	Single

6-DATE OF BIRTH, Feby 27, 1889
(Month) (Day) (Year)

7-AGE, 28 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer): Fitter 060

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Geo. W. Adam

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Marion L. Henry

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Adam

(Address) 1113 N. Milton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 191 7, to Oct 27 191 7, that I saw h[illegible] alive on Oct 26 191 7, and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Interstitial

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

10/29/17, 191... (Address) 1437 N. Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Oct 30 191 7

20-UNDERTAKER Philip Herwig

ADDRESS 1016 Oldham

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9629

CERTIFICATE OF DEATH.

81

D 9629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Roland Av St.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanna Loehmeyer

(Residence in Baltimore: No. 4002 Roland Av St.; 65 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 4 (Month) (Day), 1839 (Year)

7-AGE, 78 yrs. 5 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Kropp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Kropp

(Address) 4002 Roland Av

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 191 7, to Oct 29 191 7, that I saw h[er] alive on Oct 27 191 7, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis dont known

(Duration) yrs. mos. ds.

(Signed) Harry L. Alexander M. D.

Oct 30, 1917. (Address) 9 E Lan[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, Oct 31 191 7

20-UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

OCT 30 1917

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9630 ✓ 37 ✓ D 9630

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

2-FULL NAME Gilbert Goldman

(Residence in Baltimore: No. Nursery & Child's Hospital St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 3(?) yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Pauline Goldman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Federated Charities

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Oct 30 1917, that I saw h[illegible] alive on Oct 30 1917 and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

(a) Congenital Syphilis

.....

..... (Duration) 2 mos.

CONTRIBUTORY (Secondary).....

..... (Duration) — yrs. — mos. — ds.

(Signed) Edward P. Smith M. D.

Oct 30, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 1 mos. 10 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Nursery & Child's Hosp

Former or usual residence Nursery & Child's Hosp

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem — DATE OF BURIAL, Oct 30, 1917

20-UNDERTAKER J. Allen & Co — ADDRESS 16 W Madison St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9631

CERTIFICATE OF DEATH.

28

D 9631

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 Frederick Ave St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Severns.

(Residence in Baltimore: No. 2510 Frederick Ave St.; Life time mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widower

6-DATE OF BIRTH, August 14th, 1889 (Month) (Day) (Year)

7-AGE, 28 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Ammunition Factory

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm L. Severns,

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary R. Gerbig

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L. Severns

(Address) 2510 Frederick Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Oct. 27 1917, that I saw h[illegible] alive on Oct 24 1917, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Intussusception of bowel

(Duration) yrs. [illegible] mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 28, 191... (Address) 17[illegible] Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct. 30. 1917

20-UNDERTAKER Geo A Gerbig — ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9632

CERTIFICATE OF DEATH.

REGISTERED NO. C 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Carroll

(Residence in Baltimore: No. 525 W. Hoffman St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, February 13, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Carroll

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Martha Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 20 1917, to Oct 28 1917, that I saw her alive on October 26 1917, and that death occurred, on the date stated above, at 9 10 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(Duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct. 29, 191.7. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 9 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 525 W Hoffman St

19-PLACE OF BURIAL OR REMOVAL, Mt Zion | DATE OF BURIAL, Oct 30 191.7

20-UNDERTAKER David Easton | ADDRESS 916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9633

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9633

CERTIFICATE OF DEATH.

120

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Little George st ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Green

(Residence in Baltimore: No. 717 Little George st St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1864 (Year)

7-AGE, 53 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hamil Easter

(Address) 716 Penna ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28 (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1917, to Oct 28 1917, that I saw h.. alive on Oct 27 1917, and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophy Heart

(Duration) ... yrs. 2 mos. ... ds.

(Signed) Thos Holmes M. D.

Oct 29 1917 (Address) 1 East Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, WM Auburn — DATE OF BURIAL, Oct 31 1917

20-UNDERTAKER Hamil Easter — ADDRESS 716 Penna ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9631

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 630 German (Ext) St.; 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Richard Jones

(Residence in Baltimore: No. 630 German St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1882 (Year)

7-AGE, 35 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER, Chas Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary A. Gant.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret Curtis

(Address) 630 West German St

15-

Filed ....., 191...

Registrar.

OCT 30 1917 HARRY C. ARTHUR Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1917, to Oct 28th 1917, that I saw h[im] alive on Oct 27th 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ... yrs. ... mos. 16 ds.

(Signed) Harry F. Bunnell M. D.

Oct 29, 191... (Address) 150 E Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Centre Cem

DATE OF BURIAL, Oct 30, 191...

20-UNDERTAKER Samuel Stanley

ADDRESS 518 W Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 9635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9635

CERTIFICATE OF DEATH.

10

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Sykes

(Residence in Baltimore: No. 1465 N Carey St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, February 4, 1917
(Month) (Day) (Year)

7-AGE, yrs. 8 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Sykes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Grace Russ

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 15 1917, to October 29 1917, that I saw h m alive on October 29 1917, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia, lobar

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) broncho-pneumonia

(Duration) yrs. mos. 14 ds.

(Signed) Marcus T. Tyler M. D.

Oct. 29 191.. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1465 N Carey St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 30, 1917

20-UNDERTAKER James H Dennis

ADDRESS 1303 Presstman

Spec.—8-24-14—M. & T.—2000 Bks.

D 9626 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9626

+ 108

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hop ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Jones

(Residence in Baltimore: No. ~~Reisterstown~~ the Hospital St.; ..... yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, Unknown, 1883
(Month) (Day) (Year)

7-AGE, 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Hanson Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anne Birkett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hosp Data

(Address) Lucien Lombard

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Oct 30 1917, that I saw him alive on Oct 30 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

General Peritonitis as a following Operation due to Ruptured Appendix

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suppurative Appendicitis

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) A Lerch Gardner M. D.

10/30, 1917 (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State 6f yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ——

Former or usual residence Reisterstown Md

19-PLACE OF BURIAL OR REMOVAL, Reisterstown Md — DATE OF BURIAL, Nov 1, 1917.

20-UNDERTAKER J. F. Ellis — ADDRESS Reisterstown

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Spec.—8-24-14—M. & T.—2000 Bks.

D 9637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9637

CERTIFICATE OF DEATH.

113

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Thos Carnes

(Residence in Baltimore: No. 925 N Chester St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 21 (Day), 1874 (Year)

7-AGE, 43 yrs. 3 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edw J Carnes

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Eliza Pike

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Eliza Carnes

(Address) 422 N Washington

15-

OCT 30 1917 ROBERT P. BRAUER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 16 1917, to Oct 30 1917, that I saw h~~im~~ alive on Oct 29 1917, and that death occurred, on the date stated above, at 8:22 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) 9 yrs. 4 mos. ds.

(Signed) Edward J. Cook M. D.

10/30, 1917. (Address) 413 N Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Nov 2, 1917

20-UNDERTAKER John Herwig & Co — ADDRESS 2008 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9638

CERTIFICATE OF DEATH.

170

D 9638

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Hoffman St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Meekins

(Residence in Baltimore: No. 540 Hoffman St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colard	Single

6-DATE OF BIRTH, Oct. (Month) 2 (Day) 1860 (Year)

7-AGE, 57 yrs. 27 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Sandy Meekins

11-BIRTHPLACE OF FATHER (State or Country), Balto . Co. Md.

12-MAIDEN NAME OF MOTHER Sarah Clark

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sandy Meekins

(Address) 540 Hoffman St.

15-

Filed ....., 191.... Registrar.

OCT 30 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25 1917, to Oct 27 1917, that I saw h[illegible] alive on Oct 27 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Paresis Cerebral

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) ..... M. D.

10/30, 1917. (Address) 1 Grantholt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Zion Church Bolgna Ave. DATE OF BURIAL, Oct. 31 ....., 191...

20-UNDERTAKER A.S.Marshall ADDRESS 3539 Falls Road

D 9639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9639

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2627 ~~Bernard~~ Hampden ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Wisner

(Residence in Baltimore: No. 2627 Hampden St.: yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	W	Widower

6-DATE OF BIRTH, Oct 26, 1917.
(Month) (Day) (Year)

7-AGE, 72 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Abraham Wisner

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Ann Crowther

13-BIRTHPLACE OF MOTHER (State or Country) Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Wisner

(Address) 2627 Hampden ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno J Bowers M. D.
(Coroner.)

Oct 30, 1917 (Address) 2632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hamsted Md — DATE OF BURIAL, Oct 27, 19...

20-UNDERTAKER A D Marshall — ADDRESS 2539 Edmondson Rd

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 2610 — 104 — D 2610

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Bell

(Residence in Baltimore: No. 1849 Furman St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colred	

6-DATE OF BIRTH, ..., (Month) (Day) 1916 (Year)

7-AGE, ...1...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Ft Kinn

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Father Unknown Irene Bush

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Kirk

(Address) J. H. H.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1916.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1916, to Oct. 27 1916, that I saw her alive on Oct 27 1916, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

gastro intestinal indigestion, acute

..... (Duration).....yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

..... (Duration).....yrs.....mos.....ds.

(Signed) Margaret Tyler M. D.

Oct 29, 1916 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1849 Furman St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, Oct 29 1916
20-UNDERTAKER Commissioner Health.	ADDRESS

JOHNS HOPKINS HOSPITAL
OCT 30 1916
MEDICAL LIBRARY

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9641 **CERTIFICATE OF DEATH.** 151 D 9641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 McElderry St.: 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Smith.

(Residence in Baltimore: No. 1609 McElderry St.: —yrs., —mos. 31 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH, Sept (Month) 30 (Day), 1917 (Year)

7-AGE.	If LESS than 1 day,
—yrs.—mos. 31 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infancy
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Oct 30 1917, that I saw h-e alive on Oct 30 1917, and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Prematurity (1-8 months fourteen)

(Duration) —yrs. —mos. 30 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ....yrs....mos. 30 ds.

(Signed) John Shumway Jr. M. D.

Oct 30, 1917. (Address) Johns Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT 30 1917
20-UNDERTAKER	ADDRESS
Commissioner Health.	

OCT 30 1917 ROBERT B. KRAUTER

Burial Permit Clerk

WOODALL

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9642

CERTIFICATE OF DEATH.

40

D 9642

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lina Straus

(Residence in Baltimore: No. 211 N. Broadway St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH, Dec 27, 1846 (Month) (Day) (Year)

7-AGE. 70 years ..... yrs. 10 mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Geron Straus

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Amelia

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lina Straus

(Address) 211 Madison Ave

15-

OCT 30 1917 ROBERT R. KRAUTHS

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 9 1917, to Oct. 29 1917, that I saw her alive on Oct. 29 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

..... (Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. R. Newman M. D.

....., 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 21 ds. In the State Life yr. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 211 N. Broadway

19-PLACE OF BURIAL OR REMOVAL. Balto Hebrew Cemy

DATE OF BURIAL, Oct. 31, 1917.

20-UNDERTAKER Robert C. Fuller

ADDRESS 221 N Broadway.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9643

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2715 Tivoly Ave ST.; 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Troell

(Residence in Baltimore: No. 2715 Tivoly Ave

St. 28 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, February (Month) 29th. (Day), 1866 (Year)

7-AGE, 61 yrs. 7 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Wood Worker 086
(b) General nature of industry, business, or establishment in which employed (or employer) Wood Bot Manufacturer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John P. Troell

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Weil

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Troell

(Address) 2715 Tivoly Avenue

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 29 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17 191 7, to Oct 29 191 7, that I saw h[illegible] alive on Oct 29 191 7, and that death occurred, on the date stated above, at 11 [illegible]m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Fatty Degeneration

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) My Condition

(Duration) yrs. 2 mos. 12 ds.

(Signed) [illegible] M. D.

Oct 30, 191 7 (Address) 1[illegible] E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL. Oct. 31., 191 7.

20-UNDERTAKER Albert E Fuller

ADDRESS 221 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9611

CERTIFICATE OF DEATH.

80

D 9611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 Madison ave S. 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Pappas

(Residence in Baltimore: No. 2515 Madison St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dont know 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), St. Louis Miss.

PARENTS.

10-NAME OF FATHER, Wm. Born

11-BIRTHPLACE OF FATHER (State or Country), St. Louis, Miss.

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... V. G. Pappas

(Address)... 2515 Madison ave.

15-

OCT 30 1917 ROBERT R. KRAUTHE BURIAL PERMIT

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1914, to 10-30 1917, that I saw h[illegible] alive on 10-24 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uraemia Coma

Mitral Insufficiency

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Oct 31, 1917. (Address)..... 1422 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Louis Missouri

DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER M. L. Flynn

ADDRESS 1422 Light St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9645

CERTIFICATE OF DEATH

45

D 9645

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2309 E Monument St.; 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore C Mattes

(Residence in Baltimore: No. 2309 E. Monument St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: February 17th, 1888 (Month) (Day) (Year)

7-AGE: 29 yrs. 8 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: Carpenter (b) General nature of industry, business, or establishment in which employed (or employer): O/S

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: John Mattes

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Barbara Seeberger

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Robert Mattes

(Address) 2309 E. Monument St.

15.

Filed OCT 30 1917, 191 ..... ROBERT B. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 28th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 17th, 191 7. to. October 28th 191 7.

that I saw h[illegible] alive on October 28th, 191 7.

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder. 9 mths.

(Duration) yrs. ..... mos. ..... ds

Contributory (SECONDARY) Exhaustion 2 days.

(Duration) yrs. ..... mos. 2 ds.

(Signed) Amelia E. Fink M. D.

October 29th 191 7 (Address) 1717 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Oct 31st, 191 7

20-UNDERTAKER: Geo M. Fink

ADDRESS: Baltimore

IMPORTANT.—Answer all questions in full, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9616 — 151 ✓ — D 9616

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 E. Preston. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Matter.

(Residence in Baltimore: No. 917 E. Preston. St.; ....yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH, October 28, 1917. (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Mer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, William F. Matter

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Mary Degenhardt

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. William F. Matter.

(Address) 917 E. Preston St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 10 (Month) 30 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from 10-28 1917, to 10-30 1917, that I saw h[illegible] alive on 10-30 1917, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar - & cerebral Hemorrhage

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Oct 31, 1917

20-UNDERTAKER Henry Hoerle Son

ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9647 — D 9647

CERTIFICATE OF DEATH.

28 ✓

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. 734 N. Carrollton Ave St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Robertson Kennady

(Residence in Baltimore: No. 734 N. Carrollton Av St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. April (Month) 9 (Day), 1861. (Year)

7-AGE. 56 yrs. 6 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Penn R Road

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Isaac Kennady

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Wells

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Kennady

(Address) 715 N. Carrollton Ave

15-

OCT 31 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 28 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1917, to Oct 28 1917, that I saw him alive on Oct-28 1917, and that death occurred, on the date stated above, at 2-15 pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John D. King M. D.

Oct. 30, 1917. (Address) 1425 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lounden Park

DATE OF BURIAL, Oct. 31, 1917.

20-UNDERTAKER J O Mitchell

ADDRESS 1201 W Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9613 — 15 V — D 9613

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N Bantalow St ST.; 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Virginia Taylor

(Residence in Baltimore: No. 15 N. Bantalow St.; ..... yrs., ... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 27 (Day), 17 (Year)

7-AGE, ... yrs. ..... mos. 3 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Stacey B. Taylor.

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Anna Hall

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. B. Taylor

(Address) 15 N. Bantalow St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Oct 30 1917, that I saw her alive on Oct 30 1917, and that death occurred, on the date stated above, at 2300 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Wells Fleming M. D.

Oct. 30, 1917. (Address) 2000 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Cemetery	Nov 3rd, 191.7.
20-UNDERTAKER	ADDRESS
C. F. McCormick	1311 Hayward

Spec.—8-24-14—M. & T.—2000 Bks.

D 9643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9643

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Hallwig

(Residence in Baltimore: No. 1140 W. Pratt St. St.; 10 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 20 (Day) 1870 (Year)

7-AGE, 47 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, C. Hallwig

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Francis Hallwig

(Address) 1140 W Pratt St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Oct 29 1917, that I saw h[im] alive on Oct 29 1917, and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ...yrs. 4 mos. ...ds.

(Signed) H. Mueller M. D.

Oct 29, 1917 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 9 ds. In the State 10 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1140 W Pratt St.

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem. DATE OF BURIAL, [redacted] 10, 1917

20-UNDERTAKER John B Fields ADDRESS 1200 N Fremont

Spec.—8-24-14—M. & T.—2000 Bks.

D 9650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9650

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Sherwood ave) (St., 9 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Phillips

(Residence in Baltimore: No. 1902 Sherwood ave St.; 2 Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH. March (Month) 31st (Day), 1878 (Year)

7-AGE. 39 Yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House
(b) General nature of industry, business, or establishment in which employed (or employer). Wife

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter McLeese

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Jennie E. Harris

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Phillips

(Address) 1902 Sherwood ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 191 7, to Oct 29 191 7, that I saw her alive on Oct 27 191 7, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Adeno-Carcinoma Uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. 2 mos. ds.

(Signed) James M Fenton M. D.

Oct 29 191 7 (Address) 7 W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL. Oct 31, 191

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9651

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E Lamont St.; 9th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard - H. Bauer.

(Residence in Baltimore: No. 1628. E Lamont. St.; 2 yrs., 9 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Jan 20th (Month) (Day), 1914 (Year)

7-AGE, 2 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis F. Bauer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Jennie E. Brosh.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie E. Bauer.

(Address) 1628 E. Lamont ave

15-

Filed....., 191.....

Registrar.

4PM

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 30 1917, that I saw h... alive on Oct 30 1917, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Suffocation Pulmonary Diphtheria

..... (Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Laryngeal Diphtheria

..... (Duration) ....yrs. ....mos. 12 ds.

(Signed) [illegible] M. D.

Oct 31, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery. DATE OF BURIAL, Oct 31, 191..

20-UNDERTAKER George J. Routh ADDRESS 735 Harford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9652 D 9652

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH Union Protestant Hosp.

CITY OF BALTIMORE: (No. 1514 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis J. Detrick

(Residence in Baltimore: No. Ruxton Baltimore Co Md St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, December (Month) 25th (Day), 1888 (Year)

7-AGE, 28 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) do

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm H. Detrick

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER E. Katharine McCormick

13-BIRTHPLACE OF MOTHER (State or Country), Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Gallagan H. Detrick M.D.

(Address) Ruxton Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 30th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20th 1914, to Oct 30 1917, that I saw him alive on Oct 29th 1917, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uraemia) consequent to an acute exacerbation of a Chronic Myocarditis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis with acute exacerbations

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Wm H. Dabney M. D.

Oct 30th, 1917 (Address) Ruxton Baltimore Co. Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 9 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Acute Nephritis at Blue Ridge Summit, Pa Myocarditis at Ruxton Md

Former or usual residence Ruxton Baltimore Co Md

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, 11—1..., 1917

20-UNDERTAKER H. W. Jenkins & Sons Co — ADDRESS Orchard & McCulloh

Spec.—8 24-14—M. & T.—2000 Bks.

D 9653 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 E. Mount ST.; 16 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm E. Stevens.

(Residence in Baltimore: No. 116 E. Mount St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. June (Month) ..... (Day), 1863 (Year)

7-AGE. 54 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jno. Price

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Pitcock.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Stevens

(Address) 116 E. Mount St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from —, 191—, to Oct 30, 1917, that I saw her alive on Oct 30, 1917, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma.

Interval ..... (Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Fowler. M. D.

Oct 31, 1917. (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Edgewood Mem. Gdns. Md.	Oct. 31st, 1917.
20-UNDERTAKER	ADDRESS
C. Ashman & Son	1634 Hanover St.

D 9651

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 9651

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 32 W.Cross St. St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Thomas.(C)

(Residence in Baltimore: No. 32 E.Cross St. St.: yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Widow.

6-DATE OF BIRTH, Do not know., / (Month) (Day) (Year)

7-AGE, 50 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Talbott Co Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Thomas.(C)son.

(Address) 1002 Argyle Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29th.1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Rennhardt M. D. (Coroner.)

Oct 30, 191.7 (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	....., 191..
20-UNDERTAKER	ADDRESS
C. H. Brown & Son	108 W Monty

(If DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, OR OF A NON-RESIDENT, OR WHILE TRAVELING, OR IF DEATH WAS SUDDEN, ACCIDENTAL OR BY VIOLENCE, SEE INSTRUCTIONS ON BACK OF CERTIFICATE.)

D 9655

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D 9655

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229½ W. Pratt St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Ritter

(Residence in Baltimore: No. 2229½ W. Pratt St. St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Jan. (Month) 23 (Day) 1859 (Year)

7-AGE: 58 yrs. 9 mos. 5 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10-NAME OF FATHER: Christian Ritter

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Minnie Detering

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Ruenauer

(Address) 2229½ W. Pratt St

15-

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 28, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1917, to Oct. 28, 1917, that I saw her alive on Oct. 28, 1917, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Duration) 1 yr. mos. ds.

Contributory (SECONDARY) Dropsy

(Duration) yrs. mos. 10 ds.

(Signed) E. E. Dickey M. D.

Oct. 28, 1917. [Address] 1491 Mt. Vernon St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Bello Cemetery

DATE OF BURIAL: Oct 31 191

20-UNDERTAKER: H. Sands & Sons

ADDRESS: 1210 E. Fay

TION is very important. See instructions on back of certificate.

Spec.—8-24-14——& T.—2000 lbs.

D 9656

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D 9656

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas D. Evans

(Residence in Baltimore: No. 3034 Dillon St. St.; 70 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug. (Month) 19 (Day), 1846 (Year)

7-AGE. 51 yrs. 2 mos. 10 ds. | If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of Industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE. (State or Country), Wales

PARENTS.

10-NAME OF FATHER, Thomas Evans

11-BIRTHPLACE OF FATHER (State or Country), Wales

12-MAIDEN NAME OF MOTHER Annie Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie D. Evans

(Address) 3034 Dillon St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 29 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26th 1917, to Oct 29th 1917, that I saw him alive on Oct 29th 1917, and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

apoplexy

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) David W. Jones M. D.

10/30, 1917 (Address) 1013 E. Ellwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oakland Cem. | DATE OF BURIAL. Nov. 1, 1917.

20-UNDERTAKER Sinkler & Sinkler | ADDRESS 1739 E. Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9657

HEALTH DEPARTMENT—CITY OF BALTIMORE

43

D 9657

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Rebecca Sims

(Residence in Baltimore: No. 7 E. Franklin Bait. St.; ....yrs.,....mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. August 3 1884-1
..... (Month) 3 (Day) Jumped 1 (Year)

7-AGE. 33 yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), American Fork Montana Utah

PARENTS.

10-NAME OF FATHER, Charles R. Roberts

11-BIRTHPLACE OF FATHER (State or Country), — England

12-MAIDEN NAME OF MOTHER Mary E. Shelley Roberts

13-BIRTHPLACE OF MOTHER (State or Country), American Fork, Utah

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth M. Moyer

(Address) 1418 Eutaw Place

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Oct 29 1917, that I saw h-r alive on Oct. 29 1917, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation & Myocardial Insufficiency - due to Nephritis (Chronic)

..... (Duration) yrs. mos. 1 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast-op.

..... (Duration) yrs. 2 mos. ds.

(Signed) Elizabeth M. Moyer M. D.

Oct. 29, 1917 (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 5 ds. In the State.....yrs.....mos. 29 ds.

Where was disease contracted, if not at place of death? Meadville Montana

Former or usual residence Meadville Montana.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
American Fork, Utah	10/31, 1917.

20-UNDERTAKER	ADDRESS
Henry W. Meyer & Son	1051 N. Calvert

Via Penn. R. R. — Chas. H. Roberts — Escort

Spec.—8-24-14—M. & T.—2000 Bks.

D 9658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9658

92

REGISTERED NO. C

1-PLACE OF DEATH Aged Women Home

CITY OF BALTIMORE: (No. 1402 W Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A Scott

(Residence in Baltimore: No. Aged Women's Home St.; 77 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jas Scott

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Jane Hoey

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella J Jones

(Address) Mason

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 3rd (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 191... to Oct 30 191..., that I saw h alive on Oct 31 191..., and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Chronic)

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. 10 hrs mos. ds.

(Signed) M. D.

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? with Home

Former or usual residence Aged Women Home

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Oct 31., 191..

20-UNDERTAKER Lee J Smith — ADDRESS 1000 W Fayette

D 9659

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D 9659

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Methodist Home for Aged St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Hyde

(Residence in Baltimore: No. Methodist Home for Aged St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: January 2, 1839 (Month) (Day) (Year)

7-AGE: 78 yrs. 9 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 068

9-BIRTHPLACE (State or country): Balto Co Md.

PARENTS

10-NAME OF FATHER: William Hyde

11-BIRTHPLACE OF FATHER (State or country): Annapolis.

12-MAIDEN NAME OF MOTHER: Penelope Tilley

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Rebecca Merchant

(Address) Methodist Home.

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from Sept 30, 1917. to. Oct 30 1917.

that I saw h[illegible] alive on Oct 30, 1917.

and that death occurred. on the date stated above. at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) Several yrs. ..... mos. ..... ds

Contributory (SECONDARY) Asthma

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) Hattie Simmons M. D.

Oct 30, 1917 (Address) 2109 Garrison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 10 yrs. — mos. — ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Methodist Home for Aged

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Nov 1st, 1917

20-UNDERTAKER: Geo J Smith — ADDRESS: 1000 N Eutaw St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9660 HEALTH DEPARTMENT—CITY OF BALTIMORE 151 D 9660

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 E Hoffman ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilson Edith.

(Residence in Baltimore: No. 1002 E Hoffman st St.; ..... yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Oct. 23, 1917 (Month) (Day) (Year)

7-AGE, — yrs. — mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — none
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George E. Haas

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lula Ernst.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George E. Haas.

(Address) 1002 E. Hoffman

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-23 1917, to Oct 30 1917, that I saw h[illegible] alive on Oct 30 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Pneumatosis Cystoides - 6 Mos

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Bernard Wise M. D.

10/31, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Oct. 30, 191..

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9661 D 9661

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 233 S Chapel ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Adam Wright

(Residence in Baltimore: No. 233 S Chapel St.; 24 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 31 (Day), 1893 (Year)

7-AGE, 24 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Tender
(b) General nature of industry, business, or establishment in which employed (or employer): Mt Vernon Hotel

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, William Thos Wright

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Barbara Didmer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A Wright

(Address) 233 S Chapel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Oct 30 1917, that I saw h alive on Oct 29 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

a Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) M. D.

Oct 30, 1917. (Address) 418 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland

DATE OF BURIAL, Nov 1., 1917.

20-UNDERTAKER Wm Cook

ADDRESS 502 E Gay St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9662 D 9662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 92

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 308 Princeton place ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ruth Wilson Stokes

(Residence in Baltimore: No. 308 Princeton Pl. St.; X yrs., 5 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH. ~~Unk~~ X (Month) X (Day) 1873 (Year)

7-AGE. 44 yrs. X mos. X ds.

If LESS than 1 day, X hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) ..... X 031

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER. John Wilson

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary Eliza ? X

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wilson

(Address) 308 Princeton Pl.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29th 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25th 1917, to Oct 29th 1917, that I saw h~~e~~r alive on Oct. 29th 1917, and that death occurred, on the date stated above, at X m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

.....

..... (Duration) X yrs. X mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... ? ..... (Duration) ? yrs. ? mos. ? ds.

(Signed) Dr. Geo. L. Hall M. D.

10/30th, 1917. (Address) 1628 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. 5 mos. X ds. In the State X yrs. 5 mos. X ds.

Where was disease contracted, if not at place of death? X

Former or usual residence Gloucester Co Virginia

19-PLACE OF BURIAL OR REMOVAL. Gloucester C.H. Gloucester Co Va

DATE OF BURIAL, Nov 2, 1917

20-UNDERTAKER George N. Holland

ADDRESS 1631 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9663

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2117 Mc Henry ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll E. Wells.

(Residence in Baltimore: No. 2117 Mc Henry St.; Life time yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ (Write the word) Single

6-DATE OF BIRTH, June (Month) 21st (Day), 1897 (Year).

7-AGE, 20 yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stock Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 009

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John D. Wells.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary Bamm

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Wells

(Address) 2117 Mc Henry St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 28th (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 191 7, to Oct 28 191 7, that I saw him alive on Oct 28 191 7, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Oct 31 191 7

20-UNDERTAKER Geo A Leiby ADDRESS Baltimore

D 9661

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9661

92

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Home for Incurables 210 E Eutaw ST.; W WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Addie M. Blair

(Residence in Baltimore: No. Home for Incurables St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Unknown (Month), about (Day), 1839 (Year)

7 AGE: about 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Unknown

PARENTS

10 NAME OF FATHER: Henry Blair

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Matilda Montell

13 BIRTHPLACE OF MOTHER (State or country): Rhode Province

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. H. Bradson Hunt
(Address): 2001 E. Calvert St.

15
Filed , 191
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 30 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 08, 191, to Oct 30 191 7, that I saw h[illegible] alive on Oct 24, 191 7, and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY): Cystitis & Sepsis & infirmities of age

(Duration) yrs. mos. ds.

(Signed) C. T. Graham M. D.

Oct 31, 1917 (Address) 113 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 9 yrs. — mos. — ds. In the State — yrs. — mos. 7 ds.
Where was disease contracted, if not at place of death? Home for Incurables
Former or usual residence Home for Incurables

19 PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov 1, 1917

20 UNDERTAKER: H. L. Hughes — ADDRESS: 17 S. Broadway

To insure a PROPER RECORD of DEATH, PHYSICIANS should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9665 ✓ D 9665

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 310 E 33 d St.; 12 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William W. White

(Residence in Baltimore: No. 310 E 38 d St.; 75 yrs. 7 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 18 (Day), 1842 (Year)

7-AGE, 75 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Q 30

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John White

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane Humphreys

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C White (Wife)

(Address) 310 E 33 d St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1917, to Oct 30 1917, that I saw him alive on Oct 30 1917, and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Duration.....

Contributory.....

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(Duration) yrs. 10 mos. ds.

(Signed) Wm. Cameron Forbes M. D.

Oct 31, 191 7 (Address) 831 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, LOUDON PARK — DATE OF BURIAL, OCT 31 1917

20-UNDERTAKER ARMSTRONG-DENNY CO — ADDRESS 916 E. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 9666

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 9666

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Harford ave St.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Henry C Miller

(Residence in Baltimore: No. 1734 Harford ave St.; 71 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 10th (Day), 1846 (Year)

7-AGE, 71 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired Motorman 18
(b) General nature of industry, business, or establishment in which employed (or employer): United Elec. RR

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Christopher Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Miller

(Address) 1734 Harford ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Oct 30 1917, that I saw him alive on Oct 29 1917, and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) R G Davis M. D.

....., 191... (Address) 1509 N Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Nov 1st, 1917.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

Spec.—5-12-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 32 D 0667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Friendsbury ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert William Bowen

(Residence in Baltimore: No. 1809 Friendsbury St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Male	white	single

6-DATE OF BIRTH, Nov. 29, 1913. (Month) (Day) (Year)

7-AGE, 3 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elmer Bowen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Bessie E Warner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Warner

(Address) 1722 N Fulton Av

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 1917, to Oct 31 1917, that I saw him alive on Oct 29 1917, and that death occurred, on the date stated above, at 9.10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

.....

.....

..... (Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Spine

..... (Duration) ....yrs. 8 mos. ....ds.

(Signed) H. H. McCarty M. D.

Oct 31, 1917. (Address) 57 W Preston.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westminster Md — DATE OF BURIAL, Nov. 3, 1917.

20-UNDERTAKER M Fahey & Sons — ADDRESS 66 Fayette

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9668

CERTIFICATE OF DEATH.

D 9668

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 E Monte ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B Jaquesson

(Residence in Baltimore: No. 1028 E Monte ave St.; 2 yrs., X mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.) Widowed

6-DATE OF BIRTH, February 1st, 1851 (Month) (Day) (Year)

7-AGE, 66 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Rothermühle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. D. S. Leggett

(Address) 1028 E. Monte ave

15-

OCT 31 1917 ROBERT P. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1st 1917, to Oct 31st 1917, that I saw h er alive on Oct 30th 1917, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows: Carcinoma of uterus

Primary (Duration) — yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary) Arterio

(Duration) — yrs. 2 mos. — ds.

(Signed) J. Whitridge Williams M. D.

Oct. 31st, 1917. (Address) 2844 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER Chas E. Evans & Sn — ADDRESS 118 W Mt Royal

Spec.—8-24-14—M. & T.—2000 Blks.

D 9669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9669

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 E Pratt ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Brady

(Residence in Baltimore: No. 1717 E Pratt St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 1 (Day), 1842 (Year)

7-AGE, 75 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Brady

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Brady

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Brady

(Address) 2026 E. Lombard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 191 7, to Oct. 29 191 7, that I saw h[illegible] alive on Oct 28 191 7, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 14 ds.

(Signed) Geo. Keller M. D.

10-31, 191 7 (Address) 1937 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Nov 1, 1917
20-UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Mun

Spec.—8-24-14—M. & T.—2000 Blks.

D 9670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Dg. Hosp ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hattie Elwell

(Residence in Baltimore: No. 1626 Ashland ave St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July (Month) 21 (Day), 1849 (Year)

7-AGE, 68 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at Loom
(b) General nature of industry, business, or establishment in which employed (or employer) Gen

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burwell Elwell

(Address) 1603 N Regester

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1st (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 8 1917, to Nov 1917, that I saw h[illegible] alive on Nov 1 1917, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Uraemia and Accidents

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic Interstitial

(Duration) 2 yrs. 6 mos. ds.

(Signed) W. Todd Ferneyhough M. D.

Nov 1, 1917. (Address) Franklin Dg Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 1626 Ashland ave

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER J Herring & Co

ADDRESS 2008 Allano

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9671 — 120 — D 9671

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 802 N Pratt 18 ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Steitzner

(Residence in Baltimore: No. 802 N. Pratt St. ST.; 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: July (Month) 25 (Day), 1862 (Year)

7 AGE: 55 yrs. 3 mos. 5 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Welch

(Address) 802 N. Pratt St

15 Filed ..... 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 30 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. ..., 191..., to, Oct 31 191..., that I saw h... alive on ..., October 29, 191..., and that death occurred, on the date stated above, at 2 ... m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)

(Duration) 1 yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Jno. Lindsay Thomas M. D.

Oct 31, 191... (Address) 33 W. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 1, 1917

20 UNDERTAKER: H. B. Hammaday Son — ADDRESS: 511 W Lexington St

NOV 1 - 1917 MARY O. AS SEC'Y

Issued to ... Black

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9672

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 729 Sterling ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Richardson

(Residence in Baltimore: No. 729 Sterling r St.; yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem'l

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Bby

6-DATE OF BIRTH, Oct 22 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Richardson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Rosa. Redel

13-BIRTHPLACE OF MOTHER (State or Country), NC,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Richardson

(Address) 729 Sterling

15-

Filed....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lack of Care

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)

Oct 31, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loyal Cemetery

DATE OF BURIAL, Nov (..., 19..

20-UNDERTAKER R C Frost

ADDRESS 1405 McElderry st

Important. See instructions on back of certificate.

Spec.—8-24-14—rd. & T.—2000 Bks.

D 9673

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N Durham ST.; 7 WARD)

2-FULL NAME Virginia Truett

(Residence in Baltimore: No. 821 N Durham St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Date Known ..... (Month), ... (Day), 1 (Year)

7-AGE, 18 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Jane Truett

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Anne Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jane Truett

(Address) ..... 821 Durham St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1917, to Oct 29 1917, that I saw him alive on Oct 29 1917, and that death occurred, on the date stated above, at 7-P m.

The CAUSE OF DEATH* was as follows:

..... Tuberculosis of
..... Meninges
..... (Duration) ..... yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs
..... (Duration) ..... yrs. 2 mos. 8 ds.

(Signed) D.W. Kennard M. D.

Oct 30, 191. 7 (Address) 708 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Zion — DATE OF BURIAL, Oct ....., 191..

20-UNDERTAKER John H Owens — ADDRESS 530 Valley

D 9671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9671

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 622 W. Lexington ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Conner

(Residence in Baltimore: No. 622 W. Lexington St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Widower

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel McDougal

(Address) 222 W. Lexington

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Driscoll M. D. (Coroner.)

Oct 29 1917 (Address) 312 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Nov. 1, 1917
20-UNDERTAKER	ADDRESS
Wm Rankin	230 N. Green

NOV 1 - 1917

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9675

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital St.: 24 WARD) REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Kramer

(Residence in Baltimore: No. 218 E. Cross St. St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month), (Day), 1866 (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Attendant
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, Henry Kramer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Koch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Kramer

(Address) 1124 E Lombard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 30 (Month), (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 16 1917, to Oct. 31 1917, that I saw h.. alive on Oct. 31 1917, and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (Duration) 3 yrs. 6 mos. ds.

(Signed) W M Kerr M. D.

10/31, 191.7 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 218 E Cross St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov. 2, 191.7

20-UNDERTAKER Louis Heemann — ADDRESS 32 S Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 9676 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9676

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 E 20th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katharine Wilke Kelly

(Residence in Baltimore: No. 2229 Cecil Ave. St.; 38 yrs. 7 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, March 16, 1879 (Month) (Day) (Year)

7-AGE, 38 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. H. Wilke

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary T Hook

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D Walter C Bacon

(Address) 100 E 20th St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1917, to Oct 30 1917, that I saw her alive on Oct. 30 1917, and that death occurred, on the date stated above, at 3.45P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

About 8 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

(Signed) D Walter C Bacon M. D.

10/30/17 191... (Address) 100 E. 20th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 20 ds. In the State 38 yrs. 7 mos. 14 ds.

Where was disease contracted, if not at place of death? 2229 Cecil Ave

Former or usual residence 2229 Cecil Ave

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Nov 2, 191 7

20-UNDERTAKER Henry W Weaver Son — ADDRESS 1057 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9677

CERTIFICATE OF DEATH.

20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ella Day

(Residence in Baltimore: No. 2119 Clifton St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 27 (Day), 1884 (Year)

7-AGE, 33 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Wm. T. Wright

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Barbara Dittmar

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. T. Wright

(Address) 233 S. Chapel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 30 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Oct 30, 1917, that I saw h[er] alive on Oct 30 1917, and that death occurred, on the date stated above, at 4.55 p.m.

The CAUSE OF DEATH* was as follows:

1st Streptococcus septicaemia
(Abscess of neck)
(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure
(Duration) ....yrs. ....mos. ....ds.

(Signed) Jos. Sandlund M. D.

10/30, 191.. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State 33 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 2119 Clifton St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 2, 191.7

20-UNDERTAKER Lowe Coord

ADDRESS 802 E Fayette

over

Spec.—8-24-14—M. & T.—2000 Bks.

D 9673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 9673

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 North Gilmor ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R. Russ Jones

(Residence in Baltimore: No. 1506 N. Gilmor St 42 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct ? 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Cornelius Jones

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Jones

(Address) 1506 North Gilmor

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Oct 31 1917, that I saw him alive on Oct 31, at 1.30 Pm 1917, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows: Suddenly a fourhours - Apoplexy. I was called about 1 o'clock but not here in attendance

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis Contributory

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. E. Bond M. D.

Oct 31, 191.7 (Address) 2034 Madison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Frederick Md

DATE OF BURIAL, Nov 3rd, 191.7

20-UNDERTAKER Mullikin-Cook

ADDRESS Fort Nash

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9679 D 9679

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. 10 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lacy

(Residence in Baltimore: No. 1123 Valley St. St. 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid.

6-DATE OF BIRTH, July 12, 1845
(Month) (Day) (Year)

7-AGE, 72 yrs. 3 mos. 18 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Sarah Dempsey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov Record 191..., to ..... 191...,

that I saw h[illegible] alive on ..... 191...,

and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (Duration).....yrs.....mos.....da.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....da.

(Signed) M. Jones M. D.

Oct 31, 1917. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs. 5 mos. In the State 50 yrs. mos. da.

Where was disease contracted, if not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL, St Mary's Govans. DATE OF BURIAL, Nov 2, 1917

20-UNDERTAKER Edmund W Coughlin ADDRESS 927 E Eager

NOV 1, 1917 [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D 9680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9680

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N Bethel St. or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanna Benson.

(Residence in Baltimore: No. 416 N Bethel St.; 2 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH. oct (Month) 10 (Day), 1869 (Year)

7-AGE. 48 yrs. — mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Susanna Brason

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Benson

(Address) 416 N Bethel St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. oct (Month) 30 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 26 1917, to Oct. 30 1917, that I saw h[illegible] alive on Oct. 30, 1917, and that death occurred, on the date stated above, at 8 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ...yrs. 8 mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Oct 30 1917 (Address) 1520 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Magoths [illegible]

DATE OF BURIAL. Nov 2, 191[illegible]

20-UNDERTAKER Milton Davis

ADDRESS 413 Edmondson

Spec.—5-19-13—M. & T.—500 Bks.

D 9681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Cookie St.; 24 WARD)

REGISTERED No. C 92

2-FULL NAME Stefan Konkowski

(Residence in Baltimore: No. 1205 Cookie St.; 3 yrs., 7 mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Syl.

6-DATE OF BIRTH, March (Month) 2 (Day), 1914 (Year)

7-AGE, 3 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Konkowski

11-BIRTHPLACE OF FATHER (State or Country) Russian Poland

12-MAIDEN NAME OF MOTHER Helena Silkoska

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Konkowski

(Address) 1205 S. Cookie

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1917, to Oct. 31 1917

that I saw h alive on Oct. 31 1917

and that death occurred, on the date stated above, at 2½ m.

The CAUSE OF DEATH* was as follows:

Double (Lobar) Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. F. Warren M. D.

Nov. 1, 1917 (Address) 827 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Nov 2, 191...

20-UNDERTAKER William Faustich

ADDRESS 1615 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 9682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9682

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 Orleans ST.) 6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsa Catherine Gudemus

(Residence in Baltimore: No. 1828 Orleans St.; 11 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, May 30, 1906 (Month) (Day) (Year)

7-AGE, 11 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Frederick W. Gudemus

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Hoffert

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Gudemus

(Address) 1828 Orleans St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 30, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1915, to Oct. 1917, that I saw her alive on Oct. 30, 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pericarditis

(Duration) yrs. 3 mos. ds.

(Signed) Isaac M. Marks M. D.

Nov. 1, 1917. (Address) 1801 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL, Nov. 2, 1917

20-UNDERTAKER: Weinstein Miller — ADDRESS 2834 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9683

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1518 N. Madeira ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. M. Büttner

(Residence in Baltimore: No. 1518 N. Madeira St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 16 (Month) (Day), 1907 (Year)

7-AGE, 10 yrs. 4 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Walter Büttner

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Margaret Kantack

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Büttner

(Address) 1518 N. Madeira St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 26 1917, to Oct 29th 1917, that I saw h[illegible] alive on Oct 29 1917, and that death occurred, on the date stated above, at 11:50 m.

The CAUSE OF DEATH* was as follows:

(a) Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Pneumonia

(Duration) yrs. mos. ds.

(Signed) Edward E. Kenna M. D.

Oct 30, 1917 (Address) 1411 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetary

DATE OF BURIAL, Nov 1 1917

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9681 D 9681

CERTIFICATE OF DEATH.

42

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Hall

(Residence in Baltimore: No. 1315 Argyle Ave St.; 70 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Oct 10th, 1855 (Month) (Day) (Year)

7-AGE, 62 yrs. — mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer): Private Cook

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Oliver Hood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alphonsa Hutchins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Centerville Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30th, 1917. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 5th 1917, to Oct 30th 1917, that I saw h.er alive on Oct 29th 1917, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma of Uterus

..... (Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY Pustule Gangrenous
(Secondary)

Infection (Duration) — yrs. 2 mos. — ds.

(Signed) Edward C. MacNamara M. D.

Oct 31st, 1917. (Address) 1329 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 1, 1917

20-UNDERTAKER: Samuel Hensley — ADDRESS: 57 S Howard St

D 9685

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1 0 D 9685

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1506 N Bruce ST.: 16 WARD)

2-FULL NAME [illegible] Infant Hall

(Residence in Baltimore: No. 1006 N. Bruce St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colo	Single

6-DATE OF BIRTH, Oct. 28, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Perry Hall

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Odee Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1006 N Bruce St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct. 30, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, Nov 1, 1917

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 N Bway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9686 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9686

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Orleans ST.; 6 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Jung

(Residence in Baltimore: No. 2225 Orleans St.; 35 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Apr 22, 1861 (Month) (Day) (Year)

7-AGE, 56 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), German

PARENTS.

10-NAME OF FATHER, Frederick Ehmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline

13-BIRTHPLACE OF MOTHER (State or Country), German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Jung

(Address) 2225 Orleans

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 191.., to Oct 29 191.., that I saw h.. alive on Oct 29 191.., and that death occurred, on the date stated above, at 7 8-9 m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

Pneumonia (Duration) ...yrs. ...mos. 14 ds.

(Signed) Adam P. Leaman M. D.

Oct 30, 191.. (Address) 718 N Patterson Pk Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Nov 1, 191..

20-UNDERTAKER Philip Hennig — ADDRESS 20 E Orleans

Spec.—8-24-16—M. & T.—2000 Blks.

D 9687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9687

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 N Stockton St ST.; 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Miles

(Residence in Baltimore: No. 1318 N stockton St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Oct 30 (Month) (Day), 1895 (Year)

7-AGE, 22 yrs. — mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Frank miles

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Nancy Freland

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy miles

(Address) 1318 N Stockton.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/28 1917, to 10/31 1917, that I saw him alive on 10/31 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) B. M. Rhett M. D.

10/31, 1917. (Address) 213 W Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 2, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Pressman St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓ D 9683

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 N Stockton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Jackson

(Residence in Baltimore: No. 1338 N Stockton St.; ....yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 15, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (none) (infant)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. md.

PARENTS.

10-NAME OF FATHER, Edward Jackson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Annie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Jackson.

(Address) 1338 N Stockton

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Oct 31 1917, that I saw h~~er~~ alive on Oct 31 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration)....yrs. 1 mos....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

.....(Duration)....yrs....mos....ds.

(Signed) E Williams Jr M. D.

Nov 1, 1917 (Address) 1925 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Nov 2. 1917

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 2, 1917.

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Preston

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 9680

CERTIFICATE OF DEATH

1 PLACE OF DEATH — 1½ block this side of Kate Ave — Registered No. C 1579

CITY OF BALTIMORE: (No. Seven Oaks Old Pimlico Rd ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J. McCloskey

(Residence in Baltimore: No. Seven Oaks Old Pimlico Road St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6-DATE OF BIRTH: March (Month) 27 (Day), 1853 (Year)

7-AGE: 64 yrs. 7 mos. 3 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Keeper 830

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: John L. McCloskey

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Kearney

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mamie McCloskey

(Address) Pimlico Road

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1917, to, Nov 1 1917, that I saw h[illegible] alive on Nov 1 1917, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Dilitation of Heart

(Duration) yrs mos ds.

Contributory (SECONDARY) Heart Disease

(Duration) 3 yrs mos ds.

(Signed) John S Baber M. D.

Nov 1, 1917 [Address] 488 Park Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 3, 1917

20-UNDERTAKER: McLean & James — ADDRESS: 833 Linden Ave

IION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9690

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9690

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 McHenry St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannorah O'Connell

(Residence in Baltimore: No. 1621 McHenry St.; 59 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day) 1843 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Edward Dougherty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Conners

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Sweeney

(Address) 1902 W. Lexington St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 31, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1917, to Oct 31 1917, that I saw h[illegible] alive on Oct 30 1917, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 31, 191[illegible] (Address) 128 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Nov. 3, 1917

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 Madison Ave.

D 9691

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 ✓ D 9691

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 N. Henry St. St.; 21 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Peter Schwinn

(Residence in Baltimore: No. 718 N. Henry St St.; ..... yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Wht

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct 31, 1917 (Month) (Day) (Year)

7-AGE: ..... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: John E Schwinn

11-BIRTHPLACE OF FATHER (State or country): Balto Md.

12-MAIDEN NAME OF MOTHER: Mary Cober

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E Schwinn

(Address) 718 N. Henry St

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31, 1917, to Nov 1 191

that I saw h.. alive on Oct 31, 191.. and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Failure of Foramen Valve to Close

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Shepherd Agan M. D.

....., 191.. (Address) 137 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Nov 1st, 191..

20-UNDERTAKER: Joseph L Cook — ADDRESS: 1003 E. Lafayette St

NOV 2 - 1917 HARRY C. AN... Burial Permit

IMPORTANT.—Physicians should write the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42

D 9692

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa A. Oliver

(Residence in Baltimore: No. 213 N. Eden St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. May (Month) 19 (Day), 1844 (Year)

7-AGE. 73 yrs. 5 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION. (a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, W J Hughes

11-BIRTHPLACE OF FATHER (State or Country), Del

12-MAIDEN NAME OF MOTHER Margaret Pool

13-BIRTHPLACE OF MOTHER (State or Country), Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. Oliver

(Address) 213 N Eden

15-

Filed.....e 191.....

Registrar.

NOV 1 - 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct Oct 31, 1917

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Oct 31 1917, that I saw h[illegible] alive on Oct 30 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Clinical (Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) Senile arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Albert H. Lee M. D.

11/1/17, 191... (Address) 1207 E. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Cemetery

DATE OF BURIAL. Nov 2, 191.

20-UNDERTAKER E. Hamming

ADDRESS 1938 E Lafayette

D 9693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 9693

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3800 Frederick ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Trainor

(Residence in Baltimore: No. 3800 Frederick ave Str: yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, Feb. (Month) 4 (Day), 1900 (Year)

7-AGE, 17 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ecclesiastical

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, John J. Trainor

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Mary Laughlin

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Harding

(Address) 3800 Frederick Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart due to Excessive Exercise

(Duration) ..... yrs. ..... mos. 5 days.

CONTRIBUTORY (Secondary) Running while playing Ball

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Faulton (Coroner.) M. D.

Oct 31 1917. (Address) 700 Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Jamestown New York	Nov 1st, 1917
20-UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	1111 Fulton & Orchard Sts.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9691 ✓ 80 D 9691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 2322 Madison Ave ST.; 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ettie Greenbaum

(Residence in Baltimore: No. 2322 Madison Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, January, 1854.
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wolf Greenbaum

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hannah Bergman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) family record

(Address)

15-

NOV 1 - 1917 ROBERT P. KRAUTER

Filed, 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 31, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 1917, to October 31 1917, that I saw her alive on October 31, 1917, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary embolus

(Duration) yrs. mos. ds.

(Signed) Charles L. Greenman M. D.

Oct. 31, 1917. (Address) 1417 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chev Shalom — DATE OF BURIAL, Nov 2, 1917.

20-UNDERTAKER Harry Goodheim — ADDRESS 1118 Mt Royal

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

81 ✓ D 9695

D 9695

1 PLACE OF DEATH Emerson Hotel — Registered No. C

CITY OF BALTIMORE (No. ..... St.: 4 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edward Stevenson

(Residence in Baltimore: No. "Ward Room" 2nd. floor. 707 W Saratoga St St.: 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown, 1884
(Month) (Day) (Year)

7 AGE: 33 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Waiter 086
(b) General nature of industry, business, or establishment in which employed (or employer): Emerson Hotel

9 BIRTHPLACE (State or country): N.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Albert St Carroll

(Address) 41 E Walnut Apts

15 NOV 1 - 1917 ALBERT R. FRAUTEN

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 31 (Month) 12th (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1917 to Oct 31st 1917.

that I saw h[illegible] alive on Oct 31st 1917.

and that death occurred on the date stated above, at 12° m.

The CAUSE OF DEATH* was as follows:

Thrombosis Coronary

Unknown.
(Duration) — yrs. — mos. — ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), H. Albert St Carroll M. D.

....., 191 ..... (Address) 41 E. Walnut St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 11-3-17

20 UNDERTAKER: John H Tradmen — ADDRESS: 142 Wolfe St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9696

1-PLACE OF DEATH 2207

CITY OF BALTIMORE (No. 2207 Chelsea Terrace ST.; 15 WARD) REGISTERED No. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie L. Cox

(Residence in Baltimore: No. 2207 Chelsea Terrace St.; yrs., mos. ds.)

Important. See instructions on back of certificate. Every question must be answered. Each statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Aug. (Month) 7 (Day), 1851 (Year)

7-AGE, 66 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse 037
(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Miles

11-BIRTHPLACE OF FATHER (State or Country), Virg

12-MAIDEN NAME OF MOTHER Emma Nadx

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Newton

(Address) 2207 Chelsea Terrace

15- Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Method of Onset Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 31, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Md Upper Fairmount Somerset Co. DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER Stewart & Mowen Co. ADDRESS 10 N. North Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9697

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Glyndon ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Urbanic (Urbanic)

(Residence in Baltimore: No. 1215 Glyndon St.: ..... yrs., 5 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, ... (Month) Sept 30th (Day), 1912 (Year)

7-AGE, ... yrs. 5 mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Mathias Urbanic

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Elizabeth Domeika

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathias Urbanic

(Address) 1215 Glyndon St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Oct 31st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Oct 31st 1917, that I saw h[im] alive on Oct 31st 1917, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia

..... (Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Debility

..... (Duration) — yrs. 1 mos. — ds.

(Signed) [illegible] M. D.

Oct 31, 1917. (Address) 1328 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Oct 2nd, 1917

20-UNDERTAKER [illegible] — ADDRESS [illegible] Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 ✓ D 9693

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 E. Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul L. Fohlmeyer

(Residence in Baltimore: No. 1901 E. Monroe St.; 7 yrs., 7 mos. 31 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Child

6-DATE OF BIRTH, March 1st, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 7 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick H. Fohlmeyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bertha Geiger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick H. Fohlmeyer

(Address) 1901 E. Monroe St.

15-

Filed....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Oct 21 1917, that I saw him alive on Oct 20 1917, and that death occurred, on the date stated above, at 4.50 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 4 ds.

(Signed) Edward [illegible] M. D.

11/1/17, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery | DATE OF BURIAL, Nov 3, 191..

20-UNDERTAKER [illegible] | ADDRESS [illegible] Fayette St

Spec.—8-24-14—M. & T.—000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9699

CERTIFICATE OF DEATH.

113

D 9699

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Clinton Ave ST.; 15 WARD) REGISTERED NO. C

2-FULL NAME Wilhelmina Hemmig

(Residence in Baltimore: No. 1617 Clinton Ave St.; 36 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 22nd 1857
(Month) (Day) (Year)

7-AGE, 59 yrs. 11 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Mrs. Same

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wilhelm Hemmig

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ernestina Eichner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherina Hemmig

(Address) 1617 Clinton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 17 1917, to Oct. 30 1917, that I saw h[illegible] alive on Oct 30 1917, and that death occurred, on the date stated above, at 5 — p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Contributory

(Duration) yrs. 6 mos. 13 ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) yrs. mos. ds.

(Signed) Edgar H. Burkert M. D.

Oct. 31, 1917. (Address) 1100 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, Nov. 2, 1917

20-UNDERTAKER Mrs Wm H Smith

ADDRESS 1811 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3 N Calhoun ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Armacost

(Residence in Baltimore: No. 3 N Calhoun St.: 77 yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	widow

6-DATE OF BIRTH. Dec (Month) 1 (Day), 1839 (Year)

7-AGE. 77 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE, (State or Country), Cockeysville Md

PARENTS.

10-NAME OF FATHER, Wm Mooney

11-BIRTHPLACE OF FATHER (State or Country), Cockeysville Md

12-MAIDEN NAME OF MOTHER May Moore

13-BIRTHPLACE OF MOTHER (State or Country), Cockeysville

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Benson

(Address) Cockeysville Md

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis, Rheumatic

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart (Duration) 1 yrs. mos. suddenly ds.

(Signed) James McFinton M. D.
(Coroner.)

Oct 31, 191.7 (Address) 705 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Nov 2, 191.7
20-UNDERTAKER Robert Brookerson	ADDRESS Calhoun Hollins st

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

17
3/
8-8702

Henry Titus

HEALTH DEPARTMENT—CITY OF BALTIMORE

8702 ✓

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 525 Fremont ST.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Tittus

(Residence in Baltimore: No. 525 Fremont St.; yrs., mos. ds.)

Important. See instructions on back of certificate. Each statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Autumn, 1886
(Month) (Day) (Year)

7-AGE 31 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Steel

9-BIRTHPLACE, (State or Country). Tennessee

PARENTS.

10-NAME OF FATHER, Autumn

11-BIRTHPLACE OF FATHER (State or Country), Texas, Col'd

12-MAIDEN NAME OF MOTHER Hallums

13-BIRTHPLACE OF MOTHER (State or Country), Texas,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Brooks

(Address) 542 N Monroe

15-

Filed ....., 191.....

Registrar.

NOV 1 - 1917

ROBERT A. KLEMTNER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Louisville Ky. DATE OF BURIAL, Nov ....., 1917

20-UNDERTAKER Samuel J Kenney ADDRESS 5 E Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

9702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Greenmount Ave ST.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Ruppert

(Residence in Baltimore: No. 1027 Greenmount Ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) —

6-DATE OF BIRTH, June 10, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Driver
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Emil Ruppert

11-BIRTHPLACE OF FATHER (State or Country) Austria Hungary

12-MAIDEN NAME OF MOTHER Catherine Ault

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Ruppert

(Address) 1027 Greenmount Ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH October 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 191 7, to Oct 31 191 7, that I saw h[illegible] alive on Oct 31 191 7, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows: Acute Peritonitis

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Colon Carcinoma

(Duration) yrs. mos. ds.

(Signed) John F. Weis M. D.

Nov 1 191 7 (Address) 936 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Bals Cemetery — DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER Edmonds & Son — ADDRESS 3617 Eastern Ave

NOV 1- 1917

Please see instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

9703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 16 WARD)

*REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mable Frey

(Residence in Baltimore: No. 1522 Poplar Grove St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept. (Month) 22 (Day), 1890 (Year)

7-AGE,	If LESS than 1 day,
27 yrs. 1 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John E. Allen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amanda Addison

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda C. Allen

(Address) 1522 Poplar Grove St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1917, to Oct 31 1917, that I saw h er alive on Oct 31 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 1 ds.

(Signed) Edward H. Smith M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? 1522 Poplar Grove

Former or usual residence 1522 Poplar Grove

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Nov. 3, 1917
20-UNDERTAKER	ADDRESS
Josiah Syfer	76 W. Lexington Ave

Spec.—5-19-13—M. & T.—500 Bks.

D 9701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9701

151 ✓

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Marshall St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes G. Mathews

(Residence in Baltimore: No. 1500 Marshall St, St.: ..yrs.. mos. 4 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 28 (Day) 1917 (Year)

7-AGE, ..yrs..mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Clifton A. Mathews

11-BIRTHPLACE OF FATHER (State or Country). Crisfield, Md.

12-MAIDEN NAME OF MOTHER Minnie Gorrick

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Mathews

(Address) 1500 Marshall St

15-

Filed NOV 2 1917, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28 191 7, to Nov 1 191 7, that I saw h alive on Oct 31 191 7, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows: Pneumonia (acute)

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Wm. T. Salmon M. D.

Nov 1, 191 7 (Address) 621 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Nov 2, 1917

20-UNDERTAKER, James Dignan & Son

ADDRESS 1000 S Paca St

D 9705

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 ✓

D 9705

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1325 Sargent St ST. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rose Irlena Walsh

(Residence in Baltimore: No. 1325 Sargent St St.; 1 yrs. — mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct (Month) 20 (Day), 1916 (Year)

7 AGE: 1 yrs. mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John J Walsh

11 BIRTHPLACE OF FATHER (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Mary Ogden

13 BIRTHPLACE OF MOTHER (State or country): Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Walsh

(Address) 1325 Sargent St

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 31 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1917, to Oct 30 1917 that I saw h e alive on Oct 20 1917, and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Physical Assn M. D.

Oct 31, 191 (Address) 327 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Nov 2 ..... 191 7

20 UNDERTAKER: James Bryan & Son — ADDRESS: 1000 E. Pacca St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9706

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Linden Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank B. Yearley

(Residence in Baltimore: No. 1406 Linden Ave St.; 67 yrs., 10 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Dec 5, 1849
(Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thos. C. Yearley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Thos B C Yearley

(Address) 1319 N. Charles St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1917, to Nov 2 1917, that I saw him alive on Nov 1st 1917, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Chronic Interstitial Nephritis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward V Smith M. D.

Nov 2, 191.. (Address) 1406 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1406 Linden Ave

Former or usual residence 1406 Linden Ave

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cy

DATE OF BURIAL, Nov 5th, 1917

20-UNDERTAKER Stewart & Bowers Co

ADDRESS 1008 W North Ave

1627 Linden Ave

D 9707

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 9707

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2038 Fountain ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacot Wisniewski.

(Residence in Baltimore: No. 2038 Fountain St.: 29 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widower

6-DATE OF BIRTH, Unknow (Month) (Day) 1847 (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer 04
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

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9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Peter Wisniwski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Victoria unknow

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Wisniski

(Address) 2038 Fountain St.

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 31st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lacuna Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Tyler Smith M. D.
(Coroner.)

Nov 1, 1917 (Address) 16 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER W. F. Vadowski ADDRESS 705 S. Ann St

Important. See instructions on back of certificate.

Spec—6-19-13—M. & T.—500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9708 — 40 ✓ — C 9708

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 Fleet Street ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Politowicz

(Residence in Baltimore: No. 2230 Fleet Street St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	married

6-DATE OF BIRTH, November (Month) 1st (Day), 1862 (Year)

7-AGE, 55 yrs. mos. ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 40
(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer Works

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Anton Politowicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Politowicz wife

(Address) 2230 Fleet St

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 31st (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 8th, 1917, to October 31 1917, that I saw him alive on October 31st, 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 7 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw M Sandmann M. D.

Nov. 1, 1917 (Address) 5 N. Washington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St. Stanislaus — DATE OF BURIAL, Nov 3d, 1917.

20-UNDERTAKER W. F. Sadowski — ADDRESS 705 S. Ann

P D 9709

HEALTH DEPARTMENT—CITY OF BALTIMORE

P D 9709

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 614 warren ST. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emerika Marichi

(Residence in Baltimore: No. 614 Warren St.: Yrs., — mos. — ds.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, Feby 13, 1911
(Month) (Day) (Year)

7-AGE, 6 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sabatino Marichi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Emmanuela Michela

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sabatino Marichi

(Address) 614 Warren

15-

Filed....., 191.....
Registrar.

NOV 2 - 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia following an operation for Tonsils

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. L. Duncan M. D.
(Coroner.)

Nov 2, 1917. (Address) 3124 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cemetery	Nov 2, 1917
20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9710

CERTIFICATE OF DEATH.

42

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 E Chase ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Frank.

(Residence in Baltimore: No. 1024 E. Chase st. St.; 57 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female.

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1860 (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James T Abott.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Irvina Parks.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James T Abott.

(Address) 1211 Central Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1917, to Nov 1 1917, that I saw h.. alive on Nov 1 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Interval

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Worrall MD M. D.

....., 191... (Address) 2311 Harford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Nov. 2, 191..

20-UNDERTAKER George J. Roth

ADDRESS 1735 Harford Ave

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9711 — 151 ✓ — D 9711

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. Robert Gorsett Hospital 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Early

(Residence in Baltimore: No. 1013 West Lombard St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: July (Month) 24 (Day), 1917 (Year)

7-AGE: — yrs. 3 mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None 00
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Chas Early

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Mary Thaler

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Early

(Address) 1013 W Lombard

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 18, 1917, to, November 2 1917, that I saw him alive on November 1 1917, and that death occurred, on the date stated above, at 7:00 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) since birth yrs 3 mos. 9 ds.

Contributory (SECONDARY) .....

(Duration) yrs. mos. ds.

(Signed) John A Koch M. D.

November 2, 1917 [Address] 27 N Eutaw St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. N ds. In the State 2 yrs mos ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Robert Garrett Hospital

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Nov 3 1917

20-UNDERTAKER: John J Fields — ADDRESS: 1200 W Lombard

NOV 2 - 1917

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 S. Bunner ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Ratinsky

(Residence in Baltimore: No. 1113 S. Bunner St

St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	S

6-DATE OF BIRTH, ... (Month) Nov (Day) 1, (Year) 1917

7-AGE, 6 mo 1 day

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Raymond Ratinsky

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Skrzat

13-BIRTHPLACE OF MOTHER (State or Country), galicia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Ratinsky

(Address) 113 S Bunner St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Nov (Day) 1, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from on Nov 1 1917, to ....191...., that I saw h m alive on Nov 1 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Leo Kaplan M. D.

11/2, 1917. (Address) 2035 E' Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Nov 2, 1917.
20-UNDERTAKER	**ADDRESS**
Stephen J Fialkowski	1019 S. Ann St

Pol

D 9713

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

157

D 9713

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2115 Huntingdon Ave St.; 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Infant Moore

(Residence in Baltimore: No. 2115 Huntingdon ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single.

6 DATE OF BIRTH: Oct. 31, 1917 (Month) (Day) (Year)

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: — None
(b) General nature of industry, business, or establishment in which employed (or employer): — 000

9 BIRTHPLACE (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Joseph R. Moore

11 BIRTHPLACE OF FATHER (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Mary Downing

13 BIRTHPLACE OF MOTHER (State or country): Baltimore, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Moore

(Address) 2012 Maryland Ave

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 31, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31— 191[illegible], to Oct. 31— 1917, that I saw h..... alive on ..... 191 ..... and that death occurred, on the date stated above, at 7:05 P. m.

The CAUSE OF DEATH* was as follows:

(Premature birth) Born with mother-in-law, present for about time before I arrived. Lived about [illegible] hours.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Moore M. D.

..... 191 ..... (Address) 2012 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Holy Cross. DATE OF BURIAL: Nov 3 1917

20 UNDERTAKER: Chas. M. Gantt ADDRESS: 1124 Mt Royal Ave

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 W. Royal Ave 14th WARD) REGISTERED NO. C 80

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eunice Talbot Rowe

(Residence in Baltimore: No. 2520 W. Royal Ave St.; ...yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, About 60 yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... At home
(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Reardon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Ryan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry W. Meaps & Son

(Address) 805 W. Gilbert St.

15-

Filed ...; 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1917, to Oct 31 1917, that I saw h~~er~~ alive on Oct 31. 1917, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

...

...

...

...(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Dr. Harry Blum

...(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.

11/1—, 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, 11/3, 1917

20-UNDERTAKER, Henry W. Meaps & Son — ADDRESS 805 W. Gilbert St.

NOV 2 - 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D 9715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 ✓

D 9715

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Brickner

(Residence in Baltimore: No. 607 Gutman Ave. St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug. 15, (Month) (Day) 1853 (Year)

7-AGE, 64 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Messenger
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bernard Brickner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henrietta Schrube

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Kirk

(Address) J. H. Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Nov. 1 1917, that I saw him alive on Nov 1 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) 1 yrs. mos. ds.

(Signed) A. McGlannan M. D.

Nov. 3 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State 24 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 607 Gutman Ave.

19-PLACE OF BURIAL OR REMOVAL, Louden Pk. DATE OF BURIAL, Nov. 3, 1917.

20-UNDERTAKER Wm Cook, ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Bks.

D 9716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

D 9716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Denver ST.; 21 WARD)

REGISTERED No. C

2-FULL NAME Emerina Schmidt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 922 Denver St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Nov (Month) 14 (Day), 1831 (Year)

7-AGE, 85 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ferdynand Kundlach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Schmidt

(Address) 922 Denver St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 26th 1917, to Nov 1st 1917, that I saw h er alive on Oct 30th 1917, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

.....

.....

Heart Failure

..... (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

..... (Duration) 2 yrs. ....mos. ....ds.

(Signed) H.P. Poulton M. D.

Nov 2nd 1917. (Address) 654 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Nov. 3, 1917.

20-UNDERTAKER Wm Cook — ADDRESS 502 E Nati

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9717

CERTIFICATE OF DEATH.

D 9717

1-PLACE OF DEATH St. Vincent's Inf. Asylum. 150 ✓ REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1401 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hall.

(Residence in Baltimore: No. 1401 Division St, St.: ....yrs.. ....mos. 8 hr ~~ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. Oct 29 (Month) (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 8 hr ~~ds.~~ If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert Hall

11-BIRTHPLACE OF FATHER (State or Country), Scotland,

12-MAIDEN NAME OF MOTHER Marianna O'Brien

13-BIRTHPLACE OF MOTHER (State or Country), Elmyra N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. P. Rousseau.

(Address) 1219 Madison Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 8:00 A.M. 1917, to Oct 29, 3:30 P.M. 1917, that I saw h[illegible] alive on Oct 29, 1917 1917, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

a. Coronary Embolism Non-Cl[illegible]

b. Edema of Lungs due to

c. Heart. 8 hrs

(Duration) ....yrs. ....mos. 8 ~~ds.~~

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) Leonard M.C. Parker M. D.

Oct 29, 1917. (Address) 1114 Hollins Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 8 hrs mos. ....ds. In the State ....yrs. ....mos. 8 hrs ds.

Where was disease contracted, if not at place of death? St Vincents Infant Asylum

Former or usual residence St Vincents Infant Asylum

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Nov. 2nd, 1917.

20-UNDERTAKER M. Fahey & Sons — ADDRESS 66 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9713

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 E Eutaw St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Dewey

(Residence in Baltimore: No. 834 E Eutaw St.; ~ yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) 27 (Day) 1849 (Year)

7-AGE, 67 yrs. 10 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 066

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Frederick Dewey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Dewey

(Address) 834 E Eutaw St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mon. 1st (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Mon. 1st 1917, that I saw h alive on Oct 31st 1917, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pleurisy Effusion

..... (Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, Nov 3, 191...

20-UNDERTAKER J. H. J. Jackson — ADDRESS North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor 89 ✓ REGISTERED NO. C

CITY OF BALTIMORE: (No. 10 ST.; WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hughie Mc Williams

(Residence in Baltimore: No. Little Sisters of the Poor St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1849
(Month) (Day) (Year)

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Mc Williams

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Mullen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 191, to 191,
that I saw h[im] alive on 191[7],
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

1 day (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility of age

(Duration) yrs. mos. ds.

(Signed) F A Warner M. D.

Nov 2, 191[7]. (Address) 1132 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 9 yrs. mos. ds. In the State Entire yrs. mos. ds.

Where was disease contracted, if not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL, Catholic Cem DATE OF BURIAL, Nov 5, 191[7]

20-UNDERTAKER Chas. H. Zumbrun Son ADDRESS Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 9720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ..... WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Marshall

(Residence in Baltimore: No. Johns Hopkins Hospital St.: ..... yrs., 1 mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March 12, 1858
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
59 yrs. 7 mos. 21 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Judge 086
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Ky.

PARENTS.

10-NAME OF FATHER, John L. Marshall

11-BIRTHPLACE OF FATHER (State or Country), Ky.

12-MAIDEN NAME OF MOTHER Mary Turner

13-BIRTHPLACE OF MOTHER (State or Country), Ky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Frick

(Address) Johns Hopkins Hospital

15-

Filed ....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29 1917, to Nov. 1 1917, that I saw him alive on Nov. 1 1917, and that death occurred, on the date stated above, at 7 40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Head of Pancreas

Duration 3

CONTRIBUTORY (Secondary) Jaundice, Obstruction

(Duration) 5

(Signed) [illegible] M. D.

Nov. 2, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2012 Harwood St. Dallas Texas

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dallas. Texas	Nov. 7th, 191..

20-UNDERTAKER Joseph B Cook

ADDRESS 1003 W Baltimore St.

6 Herman Louis

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0721 — 172 — 0721

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1725 E Layfette St. WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Louis.

(Residence in Baltimore: No. 1725 E Layfette. St.; yrs., 72 mos. (X ds.) 8

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... Oct. (Month) 24, (Day) 1845 (Year)

7-AGE,	If LESS than 1 day,
72 yrs. 8 mos. ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 640

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Chas F. Louis

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margery Riddecker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Louis

(Address) 1723 Layfette

15-

NOV 2 - 1917

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Traumatism. Concussion of brain. Fell down stairs

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. Tom Grason, M. D. (Coroner.)

Nov. 2, 1917 (Address) 40 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Old St. Paul's Luth. Cem. DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER Mrs A. Rohde & Son ADDRESS 730 Park Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9722

CERTIFICATE OF DEATH.

15

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Bruce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME infant of Francois & Helen Coulard

(Residence in Baltimore: No. 708 Bruce St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	single

6-DATE OF BIRTH, Nov 1, 1917 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 4 hrs. 40 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Francois Noel Coulard

11-BIRTHPLACE OF FATHER (State or Country), N. H.

12-MAIDEN NAME OF MOTHER Helen Wohlfarth

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Francois Coulard

(Address)..... 1611 Lindenau Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 2 1917, that I saw him alive on Nov 1 1917, and that death occurred, on the date stated above, at 5-25 a m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(Duration)....yrs. 4 hours ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) H. L. Friedman M. D.

....., 191... (Address) 1611 Lindenau Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	Nov 3, 1917
20-UNDERTAKER H. C. Brauns & Son	ADDRESS 617 N Eden St

D 9723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9723

168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 Lemmon St. (or WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Winters

(Residence in Baltimore: No. 1017 Lemmon ave, St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, Oct 14, 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Retired dealer

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Martin Winters

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elzbit Luks,

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard Winters

(Address) 1017 Lemmon ave

15-

Filed NOV 2 - 1917, 191.

ROBERT B. FRAUTSCHI

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia by Illuminating Gas Accidental,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Hunt (Coroner) M. D.

Nov 1, 1917, (Address) 17 S. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Nov 5, 1917

20-UNDERTAKER, Henry Hoeck & Son

ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

D 9721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 6

D 9721

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1712 E Baltimore ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank P Rafferty

(Residence in Baltimore: No. 1712 E Baltimore St.; 53 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Steam

3 24

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Patrick Rafferty

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary Dalton

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlin Carlin

(Address) 1712 E Balto

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: 5

Suicide

Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Nov 6, 1917. (Address) ..... Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Nov 3rd 1917

20-UNDERTAKER	ADDRESS
Henry Horn & Son	1301 E Eager St

NOV 2 - 1917 ROBERT R. KRAUTER Deputy Register Clerk

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9725

9725

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Leslie ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence H. Banks

(Residence in Baltimore: No. 1533 Leslie St.; ....yrs., 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 26 (Day), 1914 (Year)

7-AGE, ...yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Milford Banks.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Viola Gross

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Banks

(Address) 1533 Leslie St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 30 191 7, to October 31 191 7, that I saw him alive on October 31 191 7, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John D. Quinn M. D.

Nov. 1, 191 7. (Address) 1507 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov. 3, 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N Leary

D 9726

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

103

D 9726

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 127 S. Ellwood ave 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth May Nelson

(Residence in Baltimore: No. 127 S Ellwood ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	

6-DATE OF BIRTH Feb 22, 1916 (Month) (Day) (Year)

7-AGE 1 yrs. 8 mos. 8 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) — 000

9-BIRTHPLACE (State or country) Balto

PARENTS

10-NAME OF FATHER Charles W. Nelson

11-BIRTHPLACE OF FATHER (State or country) Balto

12-MAIDEN NAME OF MOTHER Margaret J Elmer

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles W. Nelson

(Address) 127 S. Ellwood

15-

Filed ....., 191 .....

REGISTRAR

(over)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31, 1917, to, Nov 1, 1917, that I saw h.. alive on Nov 1, 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

Nov

..... (Duration) yrs mos. 1 ds.

Contributory (SECONDARY) Convulsions

..... (Duration) yrs. mos. 1 ds.

(Signed), R. L. Campbell M. D.

Nov 2, 1917. [Address] 1604 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Carmel. DATE OF BURIAL Nov 3nd, 1917

20-UNDERTAKER F. A. Pelouse ADDRESS 705 E Hanover St

TION is very important. See instructions on back of certificate.

18
31
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HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9727.

CERTIFICATE OF DEATH.

9V D 9727

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 812 N Vincent St. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S Miller

(Residence in Baltimore: No. 812 N Vincent St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 12, 1917
(Month) (Day) (Year)

7-AGE, yrs. 1 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William S Miller

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hannie Mott

13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 812 N Vincent

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colds & Grippe

(Duration) yrs. mos. ds.

(Signed) H. Hollander M. D.
(Coroner)

....., 191... (Address) 1621 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, OCT 2 - 1917, 19....

20-UNDERTAKER Commissioner Health

ADDRESS

NOV 2 - 1917 ROBERT R. KRAUTH Burial Permit

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9728

CERTIFICATE OF DEATH.

151

D 9728

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hospital or 30th Humpden ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	S

6-DATE OF BIRTH, about Oct. (Month) 30 (Day), 1917 (Year)

7-AGE 0 years 0 months 0 days. If LESS than 1 day, 1 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... 000
(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) John H. Morrison M. D.

Oct 30 1917 (Address) 432 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	OCT 1 - 1917, 19....
20-UNDERTAKER Commissioner Health.	ADDRESS

Bur. Wm. E. V. Of Dall

important. See instructions on back of certificate.

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Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9729

CERTIFICATE OF DEATH.

79 D 9729

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N Edw ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Burrs

(Residence in Baltimore: No. 521 N Edw St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, about 56 + + yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

243

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John Burrs

(Address)..... 521 N. Edw St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 191 7, to Oct 31 191 7, that I saw h alive on Oct 31 191 7, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: 31

1/ (a)
Acute Dilatation
1
Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Dil Stomach

0 (Duration) 0 yrs. 0 mos. 1 ds.

(Signed) Edward Fisher M. D.

Oct 31 191 7 (Address) 1612 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, OCT 1 1917, 191...

20-UNDERTAKER

ADDRESS

NOV 2 1917

Commissioner Health.

Per. Wm. E. WOODALL

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Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 9730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 9730

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Vine ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Morgan Smith

(Residence in Baltimore: No. 1012 Vine St.; 50 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Wid

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Morgan

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Morgan

(Address) 1012 Vine

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Oct 31 1917, that I saw h alive on Oct 31 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 31, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Nov 3, 1917.
20-UNDERTAKER Brown & Tucker	ADDRESS 1404 Division St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 9731

CERTIFICATE OF DEATH.

28 D. 9731

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Bush

(Residence in Baltimore: No. 809 N. Dallas St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. ....., 1 .....
(Month) (Day) (Year)

7-AGE, 25 yrs. ....mos. ....da.

If LESS than 1 day, ...hrs. or ....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER. Jacob Wright

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Fannie Kenney

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Thomas Bush

(Address) 809 N. Dallas St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 31, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1917, to Oct. 31, 1917, that I saw h[illegible] alive on Oct. 31, 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH,* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 1 yrs. ....mos. ....da.

(Signed) [illegible] M. D.

1917, (Address) 1520 N. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laural Cem

DATE OF BURIAL. November 2 1917.

20-UNDERTAKER Jno R A Wroth

ADDRESS 506 East

D 9732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9732

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 216 East St St. 5 104 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel May Bell

(Residence in Baltimore: No. 216 East St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....000....
(b) General nature of industry, business, or establishment in which employed (or employer) ....000....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Jas Bell

11-BIRTHPLACE OF FATHER (State or Country). Charles Co

12-MAIDEN NAME OF MOTHER May Scantell

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Bell

(Address) 216 East

15-

Filed ....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Grippe

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 8, 191 7 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laural Cem	Nov 3, 191 7
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	5 de East St

important. See instructions on back of certificate.

...ase of death, so that it may be properly classified. Exact statement of OCCUPATION is very

D 9733

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 9733

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2047 S Hanover ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanna Yeager

(Residence in Baltimore: No. 2047 S Hanover St.; 5 yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Femal

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct (Month) 5 (Day), 1902 (Year)

7-AGE: 15 yrs. ..... mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work: 3

(b) General nature of industry, business, or establishment in which employed (or employer): 056

9-BIRTH (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Joseph Yeager

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Annie Kahl

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Yeager

(Address) 2047 Hanover St

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Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 1 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1917, to Nov 1 1917, that I saw her alive on Nov 1, 1917, and that death occurred, on the date stated above, at 1.25a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) C M Hulse M. D.

Nov 2, 1917 (Address) 1274 Mellam Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem.

DATE OF BURIAL: Nov. 3, 1917

20-UNDERTAKER: M. J. Flynn

ADDRESS: No 2 Light St

THE CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

46

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9734

CERTIFICATE OF DEATH.

120 D. 9734

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 McKim ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius Murphy

(Residence in Baltimore: No. 830 McKim St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown Unknown, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Murphy

(Address) 830 McKim St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Oct 30 1917, that I saw h[illegible] alive on Oct 28 1917, and that death occurred, on the date stated above, at 9.38 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 6 yrs. mos. ds.

(Signed) James McPherson M. D.

Oct 31 1917 (Address) 1 East Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mns. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery DATE OF BURIAL. Nov. 3, 1917.

20-UNDERTAKER Wm J Schaeffer & Son ADDRESS 1816 Monument St

NOV 2 - 1917

REGISTRAR OF VITAL STATISTICS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9735

CERTIFICATE OF DEATH.

156 D. 9735

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1618 Light St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel E.Grove.

(Residence in Baltimore: No. 1618 Light St. St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 30th. 1889. (Month) (Day) (Year)

7-AGE, 28 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): Street car.

537 078

9-BIRTHPLACE, (State or Country), York Co Pa.

PARENTS.

10-NAME OF FATHER, Jacob H.Grove.

11-BIRTHPLACE OF FATHER (State or Country), York Co Pa.

12-MAIDEN NAME OF MOTHER Mary A.Geist.

13-BIRTHPLACE OF MOTHER (State or Country), York Co Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Agnes Anderson.(sister)
(Informant).....
(Address) 943 S.Pine St.York Pa.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1st. 1917. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas Asphyxia. Suicide.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Nov. 2nd. 1917. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Stewartstown Pa. DATE OF BURIAL, 11/3, 1917

20-UNDERTAKER J. Few McCully ADDRESS 130 E. Fort. Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D 9736

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D 9736

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1807 Frederick Av. ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca French

(Residence in Baltimore: No. 1807 Frederick Avenue St.: 79 yrs. 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED~~ WIDOWED OR ~~DIVORCED~~ (Write the word): Widowed

6-DATE OF BIRTH: March 9, 1838 (Month) (Day) (Year)

7-AGE: 79 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework at home

9-BIRTHPLACE (State or country): U.S.A. Md

PARENTS

10-NAME OF FATHER: John Liddell

11-BIRTHPLACE OF FATHER (State or country): England

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ella Wierode

(Address) 1807 Frederick Avenue

15

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 1, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 31, 1917. to Nov 1 1917.

that I saw h[illegible] alive on Nov. 1, 1917.

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 30 ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Slemmon M. D.

Nov 2, 1917. (Address) 1026 Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Balto Cemetery

DATE OF BURIAL: Nov 3, 1917.

20-UNDERTAKER: George Schnauber

ADDRESS: 2101 Eutaw Ave

NOV 2 - 1917 ROBERT B. KRAUTER

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9737

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 D 9737

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1431 Patapsco St.: 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Aldrich Bruchey

(Residence in Baltimore: No. 1431 Patapsco St.; — yrs. — mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: October 24, 1917 (Month) (Day) (Year)

7-AGE: — yrs. — mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: Chas. E. Bruchey

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Grace L. Seaman

13-BIRTHPLACE OF MOTHER (State or country): Gettysburg Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C Bruchey

(Address) 1431 Patapsco.

15-

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 24, 1917, to, Nov. 2, 1917, that I saw h[illegible] alive on Nov. 2, 1917, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) abt 8 hrs. yrs. mos. ds.

Contributory (SECONDARY) Not informed as to

at last (Duration) yrs. mos. ds.

(Signed), Robt. E. P. Schenck M. D.

Nov. 2, 1917 [Address] 1318 E. Chase St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Nov 3rd 1917

20-UNDERTAKER: Geo. Weber & Son — ADDRESS: 2503 E. Monument

TION is very important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [redacted] Schorr (Hattie)

(Residence in Baltimore: No. 3056 Brighton St. St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Apr 4, 1882 (Month) (Day) (Year)

7-AGE: 35 yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Louis Shaffenio

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Sarah Pearlman

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Keeley M.D.

(Address) Union Protestant Infirmary

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov 3, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30th 1917, to Nov 3 1917, that I saw her alive on Nov 2nd 1917, and that death occurred, on the date stated above, at 1.15 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary): Chr. arthritis

(Duration) ....yrs. ....mos. ? ds.

(Signed) C. R. Mackelfresh M. D.

Nov 3rd, 1917 (Address) U. P. I.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 1/2 ds. In the State ? yrs. .... mos. ds.

Where was disease contracted, if not at place of death? at 3056 Brighton St.

Former or usual residence Same as above.

19-PLACE OF BURIAL OR REMOVAL: Washington D.C.

DATE OF BURIAL: 11/3..., 191.7

20-UNDERTAKER: Jack Levin

ADDRESS: 1441 E. Balto St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9739 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9739

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Argyle Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie White

(Residence in Baltimore: No. 902 Argyle Ave St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, 1847
(Month) (Day) (Year)

7-AGE 60 yrs ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Jones

(Address) 902 Argyle Ave

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Nov 1 1917, that I saw h alive on Nov 1. 1917, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. G. Thiesz M. D.

Nov 2, 1917 (Address) 206 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem

DATE OF BURIAL, Nov 3, 1917

20-UNDERTAKER Edmund J Hendrix

ADDRESS 678 Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

D 9740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Kale

(Residence in Baltimore: No. Mercy Hospital St.: yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 25, 1892
(Month) (Day) (Year)

7-AGE, 25 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Cole

(Address) 121 Church St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 191..., to Nov 2 191..., that I saw h... alive on Nov 2 191..., and that death occurred, on the date stated above, at 6:50 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ....yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ....yrs. 3 mos. 6 ds.

(Signed) Edward J. Smith M. D.

....., 191... (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 17 ds. In the State Not known yrs. mos. ds.

Where was disease contracted, if not at place of death? 121 Church St. Curtis Bay

Former or usual residence 121 Church St. Curtis Bay Md

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Nov 5, 191.7

20-UNDERTAKER Frank Enoch & Son — ADDRESS 1906 Eastern Ave

D 974f

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+98 D 974f

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hopkins Hospital ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Theofidas

(Residence in Baltimore: No. ~~Repeat~~ St. a In Hospital St.; 7 yrs., 6 mos. 21 ds.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, November (Month), 1 (Day), ... (Year)

7-AGE, 24 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE. (State or Country). Greece

PARENTS.

10-NAME OF FATHER, Constantine

11-BIRTHPLACE OF FATHER (State or Country). Greece

12-MAIDEN NAME OF MOTHER Nomikou

13-BIRTHPLACE OF MOTHER (State or Country). Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Stoverpoul

(Address) 467 S. Eden

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Pulmonary Hemorrhage
2.
3.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Hartman M. D.
(Coroner.)

Nov. 2, 1917 (Address) 4 E. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 21 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Kayser W. Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wood Lawn Cem	Nov. 3, 1917

20-UNDERTAKER	ADDRESS
Frank A. Fink	915 E. Eager St

D 9742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9742

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2034 Mount St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William a Davis

(Residence in Baltimore: No. 2034 Mount St.)

St. 2 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, June 15, 16
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm a Davis

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Lenta Williams

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lenta Davis

(Address) 2034 Mount

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroner
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uncertified

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 2, 191. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, Nov 3, 17.

20-UNDERTAKER John W Henderson — ADDRESS 21 N Carolina

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9743

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 N. Montford St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Wagner

(Residence in Baltimore: No. 1605 N. Montford ave, St.; 4yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, July (Month) 12 (Day), 1872 (Year)

7-AGE, 45 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry D. Wagner

(Address) 1605 Montford Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1917, to Aug. 1st 1917, that I saw her alive on Aug. 1st 1917, and that death occurred, on the date stated above, at 1A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) 1 yrs. 1 mos. 14 ds.

(Signed) Edward C. Kellert M. D.

N.Y., 191.7 (Address) 1419 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, Aug. 5, 191.7

20-UNDERTAKER William Cook — ADDRESS 502 E. North

D 9744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 126 N Parkin Pl ST. 6 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Stub. Stubs

(Residence in Baltimore: No. 126 N Parkin Pl St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1

(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shawl maker
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Mrch

(Address) 126 N Paths Pla

15-

Filed ..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 191...

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner.)

Nov 2, 191 7 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Nov 5, 19 7

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

important. See instructions on back of certificate.

D 9745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9745

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1046 n Milton St. WARD)

2-FULL NAME Henry Wallach,

(Residence in Baltimore: No. 1046 n Milton, St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... May ..... 29 ....., 1868
(Month) (Day) (Year)

7-AGE, 49 yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Brick Oil
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Layer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Wallach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wallach

(Address) 1046 Milton

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 2 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... Coroner
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY ..... (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... (Coroner.) ..... M. D.
Nov 2, 191... (Address) ..... 711 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	Nov 5 ....., 19...
20-UNDERTAKER William Cook	ADDRESS 507 E North

N 4863

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 9746

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wyatt Johns

(Residence in Baltimore: No. 509 S. Spring St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Married

6-DATE OF BIRTH. August 6, 1882
(Month) (Day) (Year)

7-AGE. 35 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0410

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Monroe Johns

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Elizabeth Dawson

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 16 191 to Oct 18 191 , that I saw h alive on October 28 191 7, and that death occurred, on the date stated above, at 1 45 pm.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 8 yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

~~Asthma~~ (Duration) yrs. mos. 2 ds.

(Signed) C. H. Kroeger M. D.

Oct. 29, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 509 S. Spring St

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITA

DATE OF BURIAL. Oct 3 - 1917

20-UNDERTAKER Commissioner Health

ADDRESS

D 9747. HEALTH DEPARTMENT—CITY OF BALTIMORE 167 D 9747.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST. 17 WARD)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Suter
(Residence in Baltimore: No. 1711 Maryland Ave St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, Color
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 14, 1878
(Month) (Day) (Year)

7-AGE, 39 yrs. 7 mos. 18 ds.
If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Ga.

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country) Unknown
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Suter
(Address) 1711 Md. Ave

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns Gen. Caused by match ignited acute Bronchitis (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ..... (Duration) ...yrs. ...mos. ...ds.

(Signed) W. J. Ruby (Coroner.) M. D.
Nov 2, 191 7. (Address) 163 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ...yrs. 6 days mos. ...ds. In the State 18 yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence 1711 Maryland Ave

19-PLACE OF BURIAL OR REMOVAL, Ft. Hill Gen. Cem. DATE OF BURIAL, Nov 5, 1917

20-UNDERTAKER Sam'l T. Ehrlich Son ADDRESS 1400 Monroe

important. See instructions on back of certificate.

D 9748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pratt St. near Light (Reed) St.; 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	M

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, About 45 years
.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

3 46 087

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address).....

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed by B T O Car on Light St. near Reed St.
(Shock)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) W. H. Daly M. D.
(Coroner.)

Oct 20, 1917. (Address) 1629 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY.	OCT 3 - 1917, 19....
20-UNDERTAKER Commissioner Health.	ADDRESS

Per. Wm. C. [illegible]

important. See instructions on back of certificate.

50

Spec.—8-24-14—M. & T.—2000 Bks.

D 9749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9749

CERTIFICATE OF DEATH.

X146

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara V. Parker

(Residence in Baltimore: No. Womans Hospital St.; 0 yrs., 0 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, March 7 (Month) 7 (Day) 1890 (Year)

7-AGE, 67 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or estshlishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Nashua ~~Mass~~ Mass.

PARENTS.

10-NAME OF FATHER, Frances Jewett Parker

11-BIRTHPLACE OF FATHER (State or Country), Boston Mass

12-MAIDEN NAME OF MOTHER Aarma Whiting Lyman

13-BIRTHPLACE OF MOTHER (State or Country), Northfield Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth L. Cabot

(Address) 407 Beacon Boulevard, S.T. Station Mass

15-

Filed.....; 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Nov 2 1917, that I saw h[illegible] alive on Nov 2 1917, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration).....yrs.....mos. 29 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) 1.2 yrs. — mos. — ds.

(Signed) Hallie M. Clark M. D.

Nov 2, 1917. (Address) Norman Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 29 ds. In the State — yrs. — mos. 29 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Boston Mass

19-PLACE OF BURIAL OR REMOVAL, Cambridge Mass — DATE OF BURIAL, Nov 05 TS, 1917

20-UNDERTAKER Chas. H. Merrill — ADDRESS 887 Mass Ave

Cabot

Spec.—5-19-13—M. & T.—500 Bks.

D 9750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 9750

REGISTERED NO. C

1-PLACE OF DEATH 1204 Bolton St

CITY OF BALTIMORE: (No. ..... ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Grafflin Jr

(Residence in Baltimore: No. 1204 Bolton St St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~ WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 15 (Day), 1842 (Year)

7-AGE, 75 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jacob W. Grafflin

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah E. Comegys

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Margaret Grafflin

(Address) 107 E. North Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 1916, to date of death 1917, that I saw him alive on Nov 2nd 1917, and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the eye affecting also the orbit and brain

about (Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Inflammation Laryngeal (neglected)

about 15 yrs. (Duration) — yrs. — mos. — ds.

(Signed) Amanda T. Norris M. D.

....., 191... (Address) 1925 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL, Nov 7, 1917

UNDERTAKER Stewart Morris Co

ADDRESS 108 W. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9751

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

28 D 9751

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Gilbert St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Jamison

(Residence in Baltimore: No. 621 Gilbert St.; 44 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Jan 2, 1896 (Month) (Day) (Year)

7-AGE. 21 yrs. 9 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Porter
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, J H Jamison

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mamie Brown

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) J H Jamison

(Address) 621 Gilbert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Nov 2 191..., that I saw h... alive on Nov 1 191..., and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Unknown (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Unknown

(Duration)....yrs....mos....ds.

(Signed) J H Morwood M. D.

....., 191... (Address) 1537 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Nov 6, 191...

20-UNDERTAKER Edw. B. Pyle

ADDRESS 1072 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

"D 9752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 "D 9752

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 923 S. Hanover ST.; 7B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Loomis

(Residence in Baltimore: No. 923 S. Hanover St.; about 24 yrs., 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, Jan (Month) 30 (Day), 1847 (Year)

7-AGE, 70 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House ~~wife~~ work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Theodore Martin

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Loomis

(Address) 923 S. Hanover

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1917, to Nov 1 1917, that I saw her alive on Nov 1 1917, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) Over 4 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Henry C Wahl M. D.

Nov 1, 1917. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 5, 1917
20-UNDERTAKER William Cook	ADDRESS 502 N Nat

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9753

CERTIFICATE OF DEATH.

64 D 9753

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 913 Myrtle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James. H. Biddle

(Residence in Baltimore: No. 913. Myrtle Ave. St.; 72 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write this word.) Married

6-DATE OF BIRTH, Unknown (Month) ....., (Day) ....., 1839 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Insurance
(b) General nature of industry, business, or establishment in which employed (or employer)..... Collector

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Biddle

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Josephine French

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cimelia E. Biddle

(Address) 913. Myrtle Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Nov 1 1917, that I saw h— alive on Oct 31 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

..... (Duration) ..... yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ..... yrs. 2 mos. 1 ds.

(Signed) C. H. Hulse M. D.

Nov 3, 1917 (Address) 712 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 4, 1917

20-UNDERTAKER Sam'l M. Chase Son — ADDRESS 1400 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9751 D 9751

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 Gilmor ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ester Mapp

(Residence in Baltimore: No. 732 Gilmor St.: —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rena Mapp

(Address) 732 Gilmor St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1917, to Nov. 2 1917, that I saw h[illegible] alive on Nov 1, 1917, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (Duration) yrs. mos. ds.

(Signed) Jno. C. Thistle M. D.

Nov 2, 1917 (Address) 206 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov. 4, 1917

20-UNDERTAKER Joseph L Farrell — ADDRESS 2319 Division

Spec.—8-24-14—M. & T.—2000 Bks.

D 9755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D 9755

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N Broadway St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia O Davis

(Residence in Baltimore: No. 1037 N. Broadway St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Widow

6-DATE OF BIRTH, Aug 25 (Month) (Day), 1831 (Year)

7-AGE, 86 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)..000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo P. Leach

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ellen King

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Grace C. Leach.....

(Address)...1037 N. Broadway...

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Nov 2 1917, that I saw her alive on Nov. 1 1917, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)...yrs...mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration)...yrs...mos. 2 ds.

(Signed)...C. H. Macdonald M. D.

Nov. 3, 1917. (Address)...1534 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park, DATE OF BURIAL, Nov 5, 1917.

20-UNDERTAKER Wm Cook. ADDRESS 503 E. North

Dr MacDonald. Broadway & Federal.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9756

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 ✓ D 9756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1951 Edmondson St.; 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Winner

(Residence in Baltimore: No. 1951 Edmondson Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan 17, 1[illegible]
(Month) (Day) (Year)

7-AGE, 89 yrs. 9 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER ? Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rosalia Schultz

(Address) 1951 Edmondson

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Nov 2 1917, that I saw h[illegible] alive on Nov 1 1917, and that death occurred, on the date stated above, at 145a m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Howard W [illegible] M. D.

Nov 3, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 5, 1917.

20-UNDERTAKER Williams Cook

ADDRESS 508 N Gay

Jos Jones, Augusta Ga & Frederick Md

D 9757. HEALTH DEPARTMENT—CITY OF BALTIMORE D 9757.

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1815 Linden Ave St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mantz

(Residence in Baltimore: No. 1815 Linden Ave St.—yrs.,— mos.— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb. (Month) 19 (Day), 1865 (Year)

7-AGE, 52 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman 37
(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Mantz

(Address) Washington D. C.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(Duration) yrs. mos. ds.

(Signed) H. Mitchell Finn M. D.
(Coroner)

....., 191.. (Address) 19 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem'y	Nov. 5, 1917.
20-UNDERTAKER	ADDRESS
Hilbert E Fuller	221 N Broadway

Nov 3 17

important. See instructions on back of certificate.

Exact statement of OCCUPATION is very

properly classified. Exact statement of OCCUPATION is very

D 9758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+186 D 9758

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hosp'l 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Gross

(Residence in Baltimore: No. Franklin Rd. Balto Co St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colored	Married

6-DATE OF BIRTH, Nov 12, 1878
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
39 yrs. 11 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(h) General nature of industry, business, or establishment in which employed (or employer)..... Stone Quarry 253

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Gross

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, X Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Tripp M.D.

(Address) 640 Franklin Rd

15-

Filed....., 191.....
Registrar.

NOV 4 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull, Chest R. leg + L arm accidentally by Earth + Stone falling on him (Duration) ..yrs..mos. 1/2 ds.

CONTRIBUTORY (Secondary) Hemorrhage + Shock thereon (Duration) ..yrs..mos. 1/2 ds.

(Signed) James M. Faulon M. D.
(Coroner.)

Nov 1, 1917 (Address) 701 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. State 39 yrs..mos..ds.

Where was disease contracted, if not at place of death? Quarry Balto Co.

Former or usual residence. Balto Co.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Calvary Cem	Nov 4, 19..
20-UNDERTAKER Samuel Frenley	ADDRESS 5 Sh...

Important. See instructions on back of certificate. Property classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9759

HEALTH DEPARTMENT—CITY OF BALTIMORE

30 D 9759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Fuss

(Residence in Baltimore: No. 671 Sarah Ann St. Balto Md. St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 12 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Fritz

(Address) # #

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 25 1917, to Mar. 1 1917, that I saw h[illegible] alive on Mar. 1 1917, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis, tuberculous

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Lyle Chisolm M. D.

Mar. 2, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 671 Sarah Ann St. Balto Md.

19-PLACE OF BURIAL OR REMOVAL, Mt. Centre

DATE OF [illegible] Mar. [illegible] 1917

20-UNDERTAKER James J. Hensley

ADDRESS 5 E. Biddle

D 9760 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 D 9760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1618 N chapel St.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Selo.

(Residence in Baltimore: No. 1618 N. chapel St.; St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	colored	Widow

6-DATE OF BIRTH, May 3, 1840
(Month) (Day) (Year)

7-AGE, 77 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... work

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Moore

(Address) 1618 N. Chapel St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 191?
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis

(Duration) yrs. mos. ds.

(Signed) H. Mark Jenkins M. D.
(Coroner.)

Nov 2, 191? (Address) 19 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Nov. 5, 19.17

20-UNDERTAKER Robt Turner ADDRESS 1442 N. Broadway

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D 976I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 976I

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 Dolphin Ct. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Lewis

(Residence in Baltimore: No. 704 Dolphin Ct St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... " 070

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Howard Lewis

(Address) ..... 704 Dolphin Ct

15-

Filed ....., 191 .....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Doscal M. D.
(Coroner.)

Nov 7, 191.7. (Address) 1211 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Nov 11, 1917
20-UNDERTAKER	ADDRESS
Charles B Jones	235 Penn

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 9762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9762

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 410 N. Mulberry St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aubrey Hopkins.

(Residence in Baltimore: No. 410 N. Mulberry St. St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, June 21, 1847
(Month) (Day) (Year)

7-AGE, 70 yrs. 4 mos. 12 ds.

If LESS than 1 day. ....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Howard County Md

PARENTS.

10-NAME OF FATHER, Austin Hopkins

11-BIRTHPLACE OF FATHER (State or Country), Howard County

12-MAIDEN NAME OF MOTHER Mary Hammond

13-BIRTHPLACE OF MOTHER (State or Country), Howard County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Murray

(Address) Court Ave Ellicott City

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Nov 3 1917, that I saw h m alive on Nov 1 1917, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Arteriosclerosis

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) — yrs. — mos. — ds.

(Signed) Abner B. Freeman M. D.

Nov. 3, 1917 (Address) 412 Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Nov. 5, 1917

20-UNDERTAKER Geo. L. Smith ADDRESS 1000 N. Hayd

Spec.—8-24-14—M. & T.—2000 Bks.

D 9763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 East St ST.; 5 WARD) REGISTERED NO. C 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Sala.

(Residence in Baltimore: No. 311 East St. St.: Like yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 29 (Day), 1915 (Year)

7-AGE. 2 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Vincenzo Sala

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Lena Pacer

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

130

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Nov 3 1917, that I saw h-im alive on Nov 3 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 14 ds.

Laryngeal CONTRIBUTORY (Secondary) Diphtheria 18 hours

(Duration) yrs. mos. ds.

(Signed) Luigi D. DiStefano M. D.

Nov 3., 1917 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cem	Nov. 4th, 1917
20-UNDERTAKER Geo. J. Ruth	ADDRESS 1735 Harford

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9764

CERTIFICATE OF DEATH.

61

D 9764

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winifred Fatzinger

(Residence in Baltimore: No. 222 N. Bond St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, Sept. 7, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, F. B. Haltzinger

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Julia Baldheuser

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. B. Haltzinger

(Address) 222 N. Bond.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, [redacted] Nov. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Nov 4 1917, that I saw her alive on Nov. 4 1917, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Epidemic Cerebro-Spinal Meningitis

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY. ~~Autopsy Dr. Gaskin~~
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Bernard Sachs M. D.

Nov. 4, 1917. (Address) Harlem Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 6 ds. In the State — yrs. mos. ds.

Where was disease contracted, if not at place of death? 222 N. Bond.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery — DATE OF BURIAL, Nov. 5., 1917.

20-UNDERTAKER Robert E Fuller — ADDRESS 221 N Bond.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9765

CERTIFICATE OF DEATH.

REGISTERED No. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 W. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie C. Walsh

(Residence in Baltimore: No. 1209 W. Lombard St.; 31 yrs., 3 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 23 (Day), 1886 (Year)

7-AGE, 31 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Michael Walsh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jennie Bolden

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Walsh

(Address) 1209 W. Lombard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Oct 31 1917, that I saw h- alive on Oct 31 1917, and that death occurred, on the date stated above, at 6.15 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 1 ds.

(Signed) E. V. Cushwa M. D.

11/4/17, 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Nov 2, 191 7

20-UNDERTAKER M. L. Flynn

ADDRESS 1422 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9766

CERTIFICATE OF DEATH.

28

D 9766

1-PLACE OF DEATH CITY OF BALTIMORE. (No. 1239 James, St.; 21 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Chamberlain

(Residence in Baltimore: No. 1239 James St. 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, Dec. 15, 1883
(Month) (Day) (Year)

7-AGE, 33 yrs. 10 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Harford Co Md.

PARENTS.

10-NAME OF FATHER, John T. Chamberlain

11-BIRTHPLACE OF FATHER (State or Country), Harford Co Md.

12-MAIDEN NAME OF MOTHER Hannah Harwood.

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Chamberlain

(Address) 1239 James St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1917 to Nov 2 1917, that I saw h[illegible] alive on Nov 2 1917, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF ~~DEATH~~* was as follows:

Exhaustion

Phthisis Pulmonalis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Schumacher M. D.

Nov 3, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Melvale Cem. Elkridge — DATE OF BURIAL, Nov 4, 1917

20-UNDERTAKER W. L. Flynn — ADDRESS 1422 Light

Spec.—5-19-13—M. & T.—500 Bks.

D 9767

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 9767

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1952 N. Fayette ST.; 20 WARD)

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Babetta Strissler

(Residence in Baltimore: No. 1952 N. Fayette St.; 65 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (*Write* the word.) Widowed

6-DATE OF BIRTH, Jan (Month) 4 (Day), 1836 (Year)

7-AGE, 81 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Martin Strenzler

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Virginia Köbenich

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Mitchell

(Address) 1952 N. Fayette St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Nov 2 1917, that I saw h er alive on Nov 2 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Diabetes and Old age

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene

(Duration) 3 yrs. mos. ds.

(Signed) Walter E. Kirchner M. D.

Nov 3 191 7 (Address) 2002 N. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Nov 5, 191 7

20-UNDERTAKER Geo A Gerber

ADDRESS Balto & Payson

Spec.—8-24-14—M. & T.—2000 Bks.

D 9763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 9763

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Marie Axt

(Residence in Baltimore: No. 1112 Popular Grove St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

~~5-SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.)

6-DATE OF BIRTH. December (Month) 14 (Day), 1868 (Year)

7-AGE, 48 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Henry Sander

11-BIRTHPLACE OF FATHER (State or Country), Switzland

12-MAIDEN NAME OF MOTHER Anna Teuchouser

13-BIRTHPLACE OF MOTHER (State or Country), Switzland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Axt

(Address) 1112 Popular Grove St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1917, to Nov. 1 1917, that I saw her alive on Nov. 1 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis following an operation for Carcinoma of Cervix (Duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix (Duration) ? yrs. mos. ds.

(Signed) Hallie M. Clark M. D.

Nov. 1, 1917. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 11 ds. In the State 48 yrs. 11 mos. 19 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1112 Popular Grove Ave.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov. 5, 191.7

20-UNDERTAKER Geo. A. Gerber ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9769

HEALTH DEPARTMENT—CITY OF BALTIMORE

63 D 9769

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Bolton ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget A. Coyle

(Residence in Baltimore: No. 1215 Bolton St.; Lifetime yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct 15, 1847 (Month) (Day) (Year)

7-AGE, 70 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None 000

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Kehoe

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Coyle

(Address) 1215 Bolton St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3rd, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 29th, 1917, to Nov. 3rd, 1917, that I saw h[illegible] alive on Nov. 3rd - 1917, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Synovial Colum dis

(Duration) 25 yrs. mos. ds.

(Signed) Wilmer Hinton M. D.

Nov 3rd, 1917 (Address) 2244 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cem Govans | DATE OF BURIAL, Nov 6th, 1917

20-UNDERTAKER Chas S. Evans & Son | ADDRESS 1100 Royal Ave

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9770

CERTIFICATE OF DEATH.

152 D 9770

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S E Elwood ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lyona Anna Klausmeyer

(Residence in Baltimore: No. 13 S E Elwood ave St.; yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	white	sing X

6-DATE OF BIRTH, Oct 30th, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Julius Klausmeyer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Josephine Gentile

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen M Klausmeyer

(Address) 13 S E Elwood ave

15-

Filed ....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3rd, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30th 1917, to Nov 3rd 1917, that I saw her alive on Nov 3rd 1917, and that death occurred, on the date stated above, at 7 p m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Larkin M. D.

Nov 3rd, 1917. (Address) 1194 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk — DATE OF BURIAL, Nov 5, 1917

20-UNDERTAKER H. Sanders & Son — ADDRESS 1710 Pratt St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9771

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2715 Hugo ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Pieper

(Residence in Baltimore: No. 2715 Hugo ave St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 19, 1852
(Month) (Day) (Year)

7-AGE, 64 yrs. 11 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Manager Park

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Pieper

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Boerges

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helene Pieper

(Address) 2715 Hugo Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3rd, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1st 1917, to November 3 1917, that I saw him alive on November 3rd 1917, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.;

CONTRIBUTORY (Secondary) Bronchs: Pneumonia

(Duration) yrs. mos. 10 ds.

(Signed) Charles E. Link, M. D.

November 3 1917. (Address) 1717 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ball Cemetery	Nov 6, 1917
20-UNDERTAKER	ADDRESS
H. Sander Sons	1710 Park St

17
3E
8D 9772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 5 - D 9772

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Md Gen. Hospital St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ralph Reese

(Residence in Baltimore: No. 712 S. Elwood St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mch. 24, 1881
(Month) (Day) (Year)

7-AGE 36 yrs. 7 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... Tramper 086
(b) General nature of industry, business, or establishment in which employed (or employer).... Business

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Geo. Reese

11-BIRTHPLACE OF FATHER (State or Country). Md. Gone

12-MAIDEN NAME OF MOTHER Sarah Summers

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife

(Address) 712 S. Elwood

15-

NOV 5 - 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

....., 1917. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov. 7, 1917

20-UNDERTAKER H. Sander & Sons

ADDRESS 1710 Eutaw St

Important. See instructions on back of certificate. Each statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 9773

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Somerset ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME William H Lynn

(Residence in Baltimore: No. 411 Somerset St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, July 7, 1844
(Month) (Day) (Year)

7-AGE, 73 yrs. X mos. X ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Rubin Lynn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Lynn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mariah Lynn

(Address) 411 Somerset St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Nov 1 1917, that I saw h[im] alive on Oct 31 1917, and that death occurred, on the date stated above, at 11 Am m.

The CAUSE OF DEATH* was as followa:

Aortic Insufficency

Indefinite (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

..... (Duration) ..... yrs. 2 mos. 26 ds.

(Signed) J Edward Fisher M. D.

Nov 2, 1917. (Address) 1612 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Nov. 5, 1917.

20-UNDERTAKER Mrs R A Elliott — ADDRESS 506 E Cat St

D 9774 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 186

CITY OF BALTIMORE (No. 1125 North Gay St. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabel Frogdon

(Residence in Baltimore: No. 1525 N Dallas St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mas	Col	Mard

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 48 yrs. mos. ds. If LESS than 1 day, hrs. or mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
243

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Peter Frogdon

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Elezia Frogdon

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife Annie Frogdon

(Address) 1525 N Dallas St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull

Duration 1 hr. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. McSherry M. D. (Coroner.)

Nov 3, 1917. (Address) 4 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Lawn	Nov 5, 1917
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	566 Eutaw St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9775

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 108 W. Lee ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Ann Bradley

(Residence in Baltimore: No. 108 W. Lee St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widowed

6-DATE OF BIRTH, Oct (Month) 15 (Day), 1838 (Year)

7-AGE, 79 yrs. — mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Jesse Hoover

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Sallie Bartholow

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth Eliz. Bradley

(Address) 108 W. Lee St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 3 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from July 15 1912, to Nov 3, 1917, that I saw her alive on Oct 25, 1917, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

6 hrs. Interstitial nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myo. carditis

(Duration) 2 yrs. mos. ds.

(Signed) Davis Franchini M. D.

11/3/, 1917 (Address) 122 W Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary Cemetery Laurel Md. DATE OF BURIAL, Nov. 6th, 1917.

20-UNDERTAKER Fred a Krauss. ADDRESS 703 E Monument

NOV 5 - 1917 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D 9776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 9776

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N Calhoun ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie F Bonds

(Residence in Baltimore: No. 1728 N Calhoun St.; 65 yrs., 9 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.)
Male	Wh	married

6-DATE OF BIRTH, Feb 2, 1852
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 9 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): 059

883

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER. John Bonds

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Willie A Bonds

(Address) 1728 N Calhoun St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov, 1915, to Nov 3 1917, that I saw h~~im~~ alive on Nov 1 1917, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Irvin Eberhart M. D.

Nov 3, 191.. (Address) 7 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Linden Park Cemetery	Nov 6, 191.7

20-UNDERTAKER	ADDRESS
Wm A Poole & Son	13 Emmet Av

NOV 5 - 1917 ROBERT R. CRAUTER Local Registrar

D 9777.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9777.

REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1111 E. Pratt ST: 3 WARD)

2 FULL NAME Leah Binder

(Residence in Baltimore: No. 1111 E. Balto St. St.; 27 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe.

4 COLOR OR RACE: White

5 ~~SINGLE~~, ~~MARRIED~~, ~~WIDOWED~~ OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7 AGE: 77 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Binder

(Address) 1111 E Balto St

15

Filed ..., 191 ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 4 19, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1917, to Nov 3rd 1917, that I saw her alive on Nov 3rd, 1917, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 10 ds

Contributory (SECONDARY) Pulmonary Congestion & Heart failure

(Duration) ... yrs. ... mos. 1 ds.

(Signed) M. Chudeetel M. D.

Nov 4, 1917. (Address) 216 N. Eagle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1111 E Pratt St

19 PLACE OF BURIAL OR REMOVAL: Lester Jewish Run | DATE OF BURIAL: Nov 5, 1917

20 UNDERTAKER: L. Lemmon & Son | ADDRESS: 10 E Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9773

CERTIFICATE OF DEATH.

30 D 9773

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST.; 8 WARD) REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Steinert

(Residence in Baltimore: No. 1812 N. Regester St St.; 34 yrs., \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... June (Month) 2nd (Day), 1883 (Year)

7-AGE,	If LESS than 1 day,
34 yrs. 5 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Otto Steinert

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Priscilla Steinert

(Address) 1812 N. Regester St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1917, to Nov 4 1917, that I saw h him alive on Nov 4 1917, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) ..... yrs. ..... mos. 4 wks ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A. Smith M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 29 ds. In the State 3< yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1812 Regester St

Former or usual residence " "

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Baltimore County	Nov 7, 191 7

20-UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9779

CERTIFICATE OF DEATH.

64 D 9779

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 E Federal ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Bausmith

(Residence in Baltimore: No. 1304 E Federal st. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, May 11th (Month) (Day), 1844 (Year)

7-AGE, 73 years 6 mos. 21 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Wife .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Bausmith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Julia A. Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Stella Bausmith

(Address) 1334 E. Federal st.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 28 1917, to Nov 1 1917, that I saw h.. alive on Nov 1 1917, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Valvular

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 3, 1917 (Address) 1419 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cemetery	Nov 5, 1917
20-UNDERTAKER	**ADDRESS**
George J. Roth.	1735 Harford ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9780

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Conway

(Residence in Baltimore: No. 9317 Forrest St. St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, Oct 24 (Month) (Day), 1877 (Year)

7-AGE, 46 Years yrs. mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Domick F Conway.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Brigid E. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brigid E. Smith

(Address) 9317 Forrest st.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 3 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1917, to Nov. 3, 1917, that I saw her alive on Nov. 3, 1917, and that death occurred, on the date stated above, at 3 am m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (intestinal)

(Duration) yrs. mos. 5 ds.

(Signed) J. Edw. Norris M. D.

11 | 3 | 17 191... (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 15 ds. In the State Life yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 9317 Forrest St.

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery DATE OF BURIAL, Nov. 6, 191.7

20-UNDERTAKER George L. Rutt ADDRESS 1735 Harlem ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9781

CERTIFICATE OF DEATH.

40 D 9781

REGISTERED NO. C

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Aliceri ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Rhodes

(Residence in Baltimore: No. 123 Calhoun st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown about 1867
(Month) (Day) (Year)

7-AGE. about 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Washing

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas Bracco

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lizzie Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Brown

(Address) 161 Calhoun st

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1917, to Nov 3 1917, that I saw her alive on Nov 3 1917, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Inoperable)
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion
(Duration) yrs. mos. 4 ds.

(Signed) Thos Burke M. D.

....., 191... (Address) 20 Gay Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Dr's Room

Former or usual residence 112 Calhoun st

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Nov 5, 191 7.

20-UNDERTAKER Geo H Holland — ADDRESS 161 Hanover

NOV 5 - 1917 ROBERT B. KLAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9782

CERTIFICATE OF DEATH.

84 D 9782

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1718 E. Lanvale St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Maisch

(Residence in Baltimore: No. 1718 E. Lanvale St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov. 11, 1843
(Month) (Day) (Year)

7-AGE, 71 yrs. 11 mos. 27 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Daniel Henritz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. H. Maisch

(Address) 1718 E. Lanvale

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 3 1917, that I saw her alive on Nov 3 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

1

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Maisch M. D.

Nov. 4, 1917. (Address) 26 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 6, 1917.

20-UNDERTAKER Fickler & Fickler — ADDRESS 1737 E. Eager

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

"D 9783

CERTIFICATE OF DEATH.

64 "D 9783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 St Paul St.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Richardson Dorsey

(Residence in Baltimore: No. 1107 St Paul St.; 2 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED or DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, November (Month) 22 (Day), 1848 (Year)

7-AGE, 68 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Vice Pres Wm E Hooper & Sons Co
(b) General nature of industry, business, or establishment in which employed (or employer): Cotton Duck Mfg

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James L Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Dorchester County

12-MAIDEN NAME OF MOTHER Sarah A W Richardson

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L Dorsey

(Address) 314 Abell Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 3rd (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1917, to Nov 3rd 1917, that I saw him alive on Nov 2nd 1917, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

.....

(Duration) .....yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) Constant Epileptic Convulsions

(Duration) 10 to 15 yrs. mos. ds.

(Signed) Geo H Baines M. D.

Nov 3rd, 1917. (Address) 2121 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet — DATE OF BURIAL, 11....5...., 1917

20-UNDERTAKER Henry H. Jenkins & Sons Co — ADDRESS Howard & McCulloh

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

"D 9781

CERTIFICATE OF DEATH.

30 "D 9781

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Ramsay St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustave Trump. (Trump.)

(Residence in Baltimore: No. 1840 Ramsay St St.; — yrs., 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Feb ?, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 9 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Carl Trump.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Helen Reinhardt.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Carl Trump.

(Address) 1840 Ramsay St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 14 1917, to Nov 3 1917, that I saw h[illegible] alive on Nov 3 1917, and that death occurred, on the date stated above, at 3 25 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonitis

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry E. Ohler M. D.

Nov 3, 1917 (Address) 1203 N. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Nov 5, 1917

20-UNDERTAKER	ADDRESS
Harry P. Wiltz Co	Forest, Lombard

NOV 5 - 1917

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9785

CERTIFICATE OF DEATH.

89 D 9785

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 So Wincent ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Marie Grady

(Residence in Baltimore: No. 415 So Vincent St; St.; yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. October 9, 1917 (Month) (Day) (Year)

7-AGE. — yrs. — mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Grady

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Maud Stevens

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grady

(Address) 415 So Vincent Av

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 3, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1917, to Nov 2 1917, that I saw her alive on Nov 2 1917, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. 7 ds.

(Signed) Theo. H. Waldeck M. D.

Nov 5, 191 7 (Address) 345 Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. Nov 5, 191 7

20-UNDERTAKER F. B. Shepherd

ADDRESS 775 Fred'k Av

NOV 5 - 1917 ROBERT J. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9786

CERTIFICATE OF DEATH.

D 9786

1-PLACE OF DEATH Maryland General Hospital REGISTERED No. C.....

CITY OF BALTIMORE: (No. Linden Ave Md. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Trimm

(Residence in Baltimore: No. Mt General Hospital St.; ....yrs.,....mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Dec 12 (Month) (Day), 1849 (Year)

7-AGE, 67 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Fuderman

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md.

12-MAIDEN NAME OF MOTHER Susie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Naylor D. Trimm

(Address) Woodlawn Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Octbr 21 1917, to Nov. 3 1917, that I saw h.. alive on Nov. 3 1917, and that death occurred, on the date stated above, at 7.05 m.

The CAUSE OF DEATH* was as follows: Cardiac Dilatation

Operation (Duration) ...yrs. ...mos. 1/2 ds.

CONTRIBUTORY (Secondary) Sarcoma of Testes

times (Duration) ...yrs. 9 mos. ...ds.

(Signed) J. D. Roberts M. D.

11-3-17, 191.7 (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 13 ds. In the State 67 yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ———

Former or usual residence Woodlawn Md.

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet Cem Baltimore Md | DATE OF BURIAL, 11-5-17, 191.7

20-UNDERTAKER Joseph D Cook | ADDRESS 1027 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9787.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54 D 9787.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 N. Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adeline Rutherford

(Residence in Baltimore: No. 830 N. Calhoun St.; 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, March 26 (Month) (Day), 1842 (Year)

7-AGE, 88 yrs. 7 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER. John Henry Young

11-BIRTHPLACE OF FATHER (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Sarah A. Pollard

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Donald

(Address) 830 N. Calhoun St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Nov. 1917, that I saw h ER alive on Novem 2 191, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

1. Chronic Nephritis
2. Old age

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Jno. [illegible] M. D.

Nov. 4, 1917. (Address) 830 N. Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Glen Mount Cem. DATE OF BURIAL, Nov. 6, 191..

20-UNDERTAKER Joseph R. Cook ADDRESS 1031 N. Eutaw St

Spec.—5-19-13—M. & T.—500 Bks.

Samuel Shuman

D 9788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9788

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Garrison & Boorman Ave 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Shuman

(Residence in Baltimore: No. Garrison & Boorman Ave St.; 10 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, May (Month) 16 (Day) 1827 (Year)

7-AGE, 90 yrs. 5 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Steamboat Captain

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, George Shuman

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Hulda Bowman

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. R. Osborn

(Address) Garrison & Boorman

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 2 1917, that I saw him alive on Nov 2 1917, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis.

Duration 2 days.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

(Signed) H. Nicarmon M. D.

11-5-17, 191... (Address) 901 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Nov 5th, 191.

20-UNDERTAKER Joseph B Cook — ADDRESS 1003 W Balto St

NOV 5 - 1917
Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

D 9789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

REGISTERED No. C D 9789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 Mosher ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles S. Thomas.

(Residence in Baltimore: No. 419 Mosher St.: 61 yrs., 3 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1856 (Year)

7-AGE, 61 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter 086.
(b) General nature of industry, business, or establishment in which employed (or employer): Hat store

6440

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Chas. Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Ayers

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie R. Thomas

(Address) 419 Mosher St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2nd (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1917, to Nov. 2nd 1917, that I saw h[illegible] alive on Nov. 2 1917, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

4

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Coma.

(Duration) ....yrs. ....mos. 3 ds.

(Signed) W. J. Carr M. D.

Nov. 4, 1917. (Address) 515 Mosher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Nov. 5th 1917

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Etting St.

17
05-
821 9790

Joseph Sewell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 9790

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2117 Division St.: Denison (Walbrook) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Sewell

(Residence in Baltimore: No. 543 N. Paddle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1882 (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

243

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER James Sewell

11-BIRTHPLACE OF FATHER (State or Country), Md Ire.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Sewell

(Address) 543 N. Biddle

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(b) .....

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, Nov ....., 1917

20-UNDERTAKER Samuel Frazier ADDRESS 578 N. Eden

important. See instructions on back of certificate.

D 9791

Mary S. Martin

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

27 - D 9791

1-PLACE OF DEATH 642 W. Mott St.

CITY OF BALTIMORE (No. 642 W Mott St) REGISTERED No. C

2-FULL NAME Mary S Martin — St: 17 WARD)

(Residence in Baltimore: No. 861 N. Franklin St.

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	colored	widow

6-DATE OF BIRTH: Seventh (Month) First (Day), 1867 (Year)

7-AGE: 50 yrs. 4 mos. 1 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private Family

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: James Bagwell

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Susie Rogers

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Sewell

(Address) 741 Franklin St

15.

Filed NOV 5 - 1917, 191 ROBERT R. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 2 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1917, to Nov 2 1917.

that I saw h[illegible] alive on Nov 2, 1917.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Mitral Insufficiency)
(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed), [illegible] M. D.

Nov 2, 191.. (Address) 7[illegible] N. Mar.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 7, 191

20-UNDERTAKER: Samuel Stanley — ADDRESS: 5 Saw Bridle

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should be stated EXACTLY.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9792

CERTIFICATE OF DEATH.

79 D 9792

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 N. Wolfe ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest H. Troester

(Residence in Baltimore: No. 1818 N. Wolfe St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Sept 22, 1841
(Month) (Day) (Year)

7-AGE, 76 yrs. 1 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): retired 1 year

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Friederich Troester

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie Roth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Stanclift

(Address) 1818 N. Wolfe St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Nov 4 1917, that I saw h[im] alive on Nov 4 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

1. Exhaustion of old age
2. Coma
3. Mitral Insufficiency
4. 6 mos (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) Fred W. Taylor M. D.

Nov 5, 1917 (Address) 1924 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery

DATE OF BURIAL, Nov. 7, 1917

20-UNDERTAKER H. Sander Son

ADDRESS 1710 Hoch St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9793

CERTIFICATE OF DEATH.

120 D 9793

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Milton Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernhard Schuchmann

(Residence in Baltimore: No. 523 S. Milton Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 13 (Day), 1879 (Year)

7-AGE, 38 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bryan atter
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Baltimore City Md.

PARENTS.

10-NAME OF FATHER, William Schuchmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katherine Strobel

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose L. Schuchmann

(Address) 523 S. Milton Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1917, to Nov. 3 1917, that I saw h in alive on Nov. 2nd 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

1. Intestinal Hemorrhage

2.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Heart Disease

(Duration) yrs. 6 mos. ds.

(Signed) Robert X. Stark M. D.

Nov. 3rd, 1917. (Address) 100 N. Lakewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cemetery DATE OF BURIAL, Nov. 6, 191...

20-UNDERTAKER L. Vander Sons ADDRESS 1710 Pine st

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9791

CERTIFICATE OF DEATH.

D 9791

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Luzerne Ave ST.; 6 WARD)

2-FULL NAME Joseph Dukes Sr.

(Residence in Baltimore: No. 405 N. Luzerne Ave St.; 78 yrs., 1 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 12 (Month) (Day), 1839. (Year)

7-AGE,	If LESS than 1 day,
77 yrs. 1 mos. 23 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Statesman 030
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Elizabeth Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Liverpool England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. Dukes

(Address) 405 N. Luzerne Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 4 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from For last years 8 191..., to 191...,
that I saw h... alive on Oct 27 191 7,
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

several

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Bullock M. D.

Nov 7, 191 7. (Address) 444 N. Luzerne Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery

DATE OF BURIAL, Nov 7, 191 7.

20-UNDERTAKER H. Sander & Sons

ADDRESS 1100 Pleasant St

DR ALBERT E. GOLDSTEIN
444 N. LUZERNE AVE.
BALTIMORE, MD

Mar 12/18

To whom it may concern:

This is to certify that the duration the disease causing the death of Jos. Kubes was only several days and several years as stated in the death certificate

Yours truly

A E Goldstein MD

Subscribed and sworn to before me
this 12 day of March 1918

Mat F Eastwood

NOTARY PUBLIC

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9795

CERTIFICATE OF DEATH.

51 D 9795

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2807 Huntington Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frida Bernard

(Residence in Baltimore: No. 2807 Huntington Ave St.; ..... yrs., 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 12th, 1917
(Month) (Day) (Year)

7-AGE, 0 yrs. 2 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Bernd Bernard

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sofie Secher

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernd Bernard

(Address) 2807 Huntington Ave.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10th 191 7, to Nov 5th 191 7, that I saw h[illegible] alive on Nov 4th 191 7, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Pleuritis Congestion of Lungs

(Duration) yrs. mos. 1 ds.

(Signed) R. L. Norment M. D.

Nov 6, 191 7. (Address) 3342 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Workmen's Circle Mt. Carmel Rd. | DATE OF BURIAL, Nov. 6, 191 7.

20-UNDERTAKER Jack Davis 1411 | ADDRESS E. Balto St.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9796

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 9796

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E. Cross ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hettie Lee North

(Residence in Baltimore: No. 217 E Cross St.; 40 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	married

6-DATE OF BIRTH, Feb 20 (Month) (Day), 1865 (Year)

7-AGE, 52 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework at
(b) General nature of industry, business, or establishment in which employed (or employer)..... home 037

9-BIRTHPLACE, (State or Country), Somerset Co Md

PARENTS.

10-NAME OF FATHER, Thomas Feeby

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Archie Ross (Son)

(Address) 1411 W. Lafayette Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Nov 4 1917, that I saw h.. alive on Nov 3rd 1917, and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

.....

Uterine Cancer

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

..... (Duration) yrs. 3 mos. ds.

(Signed) Jno B Coll M. D.

Nov 7, 1917 (Address) 1702 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oriole Md	Nov. 6, 1917.
20-UNDERTAKER Armstrong & Denny Co.	ADDRESS. 715 Light St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 9797

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Prot Infirmary ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis A. Soper.

(Residence in Baltimore: No. 2505 N. Chas. St. St.; yrs., mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Sept. (Month) 8 (Day) 1849 (Year)

7-AGE.	If LESS than 1 day,
68 yrs. 1 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Supt. of Schools
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. W.H. Soper

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Eliza Collins

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C.C. Keely M.D.

(Address) U. of Infirmary

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17th 1917, to Nov 2nd 1917, that I saw him alive on Nov. 1st 1917, and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(Duration)....yrs....mos....5..ds.

CONTRIBUTORY (Secondary) Diabetes

Nephritis (Duration) 1 yrs.....mos.....ds.

(Signed) G.R. Micklethwaite M. D.

Nov. 2, 1917. (Address) Union Prot. Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2505 N Chas St.

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov. 5, 1917

20-UNDERTAKER H.J. Adams for Worthington

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

9798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9798

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Oakley ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Albaugh

(Residence in Baltimore: No. 2015 Oakley St. St.; ....yrs.,. 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Married

6-DATE OF BIRTH, May 31, 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home 037

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. B. Belcher

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Georgiana Wilderman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. S. Albaugh

(Address) 2015 Oakley St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 17 1917, to Nov 2 1917, that I saw her alive on Nov 2 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

.....

.....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. E. Knight M. D.

Nov 4, 191.. (Address) 1502 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet	Nov 5, 191..

20-UNDERTAKER	ADDRESS
W. J. Lockard & Sons	Martin Pa

Spec.—8-24-14—M. & T.—2000 Bks.

D 9799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9799

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1938 Eight St. 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Mr & Mrs Howard S. Jenkins

(Residence in Baltimore: No. 1938 Eight St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 3, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Howard S. Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rose E. Goodwin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jenkins

(Address) 1938 Eight St

15-

NOV 5 - 1917 ROBERT R. KRAUTER

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov 3 1917, that I saw h alive on Nov 3 1917, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

I. Congenital Debility

II. Premature Birth

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Malformation

(Duration) ..... yrs. 1000 mos. ..... ds.

(Signed) R. L. Campbell M. D.

Nov 3, 1917 (Address) 1645 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Nov 5, 1917

20-UNDERTAKER Geo L Schwab & Bro

ADDRESS 201 Eutaw Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9800

CERTIFICATE OF DEATH.

79 D 9800

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Wolfe ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine J. Sommers

(Residence in Baltimore: No. 217 N Wolfe St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 19 (Month), 1852 (Day) (Year)

7-AGE, 65 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 037

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John J. Dressel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sommers

(Address) 217 N. Wolfe

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1st (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Nov. 1 1917, that I saw h.r alive on Oct 31, 1917, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) C. B. Britton M. D.

Nov 2, 1917. (Address) 1711 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Nov 5, 1917

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

D 9801 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9801

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 902 Harnden Court. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Williams.(C)

(Residence in Baltimore: No. 105 W. Hughes St. St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Single.

6-DATE OF BIRTH. Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE. ....24....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

243

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)..... Sarah Matthews.(C)
(Address)..... 11 W. Hughes St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 31st. 1917. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)
Nov, 6, 7, 191... (Address) 1917 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn.	Nov 8 1917
20-UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Lee

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very property classified. It may be

Spec.—8-24-14—M. & T.—2000 Blks.

D 9802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9802

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S Chester ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha M Roberts

(Residence in Baltimore: No. 319 S Chester St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 27, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

8-C

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Roberts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Beron

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charley Roberts

(Address) 319 S Chester St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 1 1917, that I saw h[illegible] alive on Nov 1 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

1.
Pneumonia Entero

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) A L Gunther M. D.

Nov 3, 191.. (Address) 2013 E Pr St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Nov 3, 191..

20-UNDERTAKER John A Thomas

ADDRESS Bond & Aisquith

Spec.—8-24-14—M. & T.—2000 Bks.

D 9803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9803

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2057 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Foster

(Residence in Baltimore: No. 2051 Division St.; 5 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1851 (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Novel
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Owens

(Address) 538 Dolphin Av

15-

Filed ....., 191.....

Smith Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Nov 4 1917, that I saw h in alive on Nov 4 1917, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw. Shorb M. D.

Nov 5, 1917 (Address) 1812 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest Cemetery

DATE OF BURIAL, Nov 6, 1917

20-UNDERTAKER John F Owens

ADDRESS 538 Dolphin St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9804

D 9804

CERTIFICATE OF DEATH.

64 ✓

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Peach alley ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Spriddle

(Residence in Baltimore: No. 929 ~~Linn~~ Peach St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Hiram Woods

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Louisa Weaver

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Spriddle

(Address) 929 Peach alley

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 2, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 191 7, to Nov. 1st 191 7, that I saw her alive on Nov. 1st 191 7, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,
(Coma, Paralysis)
10 Da
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. da.

(Signed) L. A Keene M. D.

Nov. 3., 191 7. (Address) 522 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov. 5., 191 7.

20-UNDERTAKER Jno. H. Broadwin — ADDRESS 142 Wilk St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hanover Hospital St.; WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Jirzgal

(Residence in Baltimore: No. 2015 Hollen Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1891
(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waitress
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Ludwig Jedraitis

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Jozefaitis

(Address) 646 W. Lombard St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1917, to Nov. 3 1917, that I saw h[illegible] alive on Nov. 3 1917, and that death occurred, on the date stated above, at 8:20 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

with pregnancy

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Central Pregnancy Pelvis

(Duration) [illegible] yrs. mos. ds.

(Signed) [illegible] M. D.

11/3, 191.7 (Address) Hanover, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? [illegible]

Former or usual residence 2015 Hollen Ave

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Nov. 7, 191.7

20-UNDERTAKER John Grebiancken ADDRESS 425 S. Bro[illegible]

RECEIVED
NOV 5 - 1917
Vital Records Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9806

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

X 167 D 9806

REGISTERED No. C

CITY OF BALTIMORE (No. Lt Gorgs Hospital St.) 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Langlotz.

(Residence in Baltimore: No. Shell Road Balto Co. St.) 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 12 (Day), 1857 (Year)

7-AGE, 6 6 yrs. 5 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Germ

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germ

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Langlotz

(Address) Shell Road

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 5 (Day), 191 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns, mandata & abs 6 days & Collapse & Shock

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. [illegible] M. D. (Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 66 yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Shell Road Balto Co

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, First Ev. L. German — DATE OF BURIAL, Nov 7, 1917.

20-UNDERTAKER, W. F. Sadowski — ADDRESS 705 S. Ann

NOV 5 1917 ROBERT R. KRAUTER SOCIAL PROBLEMS

important. See instructions on back of certificate.

D 9807.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

52 ✓

D 9807.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 903 Forrest St.: 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Edna Kinsella

(Residence in Baltimore: No. 903 Forrest St.: yrs. ..... mos. 2 Hours ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: November 4, 1917 (Month) (Day) (Year)

7-AGE: ..... yrs. ..... mos. 2 Hours ds. If LESS than day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Joseph P. Kinsella

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary A. Byrnes

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Joseph P. Kinsella

(Address) 903 Forrest St

15.

Filed ....., 191....

REGISTRAR

NOV 5 - 1917 ROBERT P. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 11 (Month) 4 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/4, 1917, to 11/4 1917.

that I saw h ex alive on 11/4, 1917.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

injury by
Breech presentation & delivery.

(Duration) ..... yrs. ..... mos. 4 hours ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed). A. L. Hornstein M. D.

11/4, 1917. (Address) A. L. Hornstein

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: November 5, 1917

20-UNDERTAKER: Henry Storck Son

ADDRESS: 1301 E. Eager St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9808

CERTIFICATE OF DEATH.

47 ✓ D 9808

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2236 E. Lanvale St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude E. Sheckell

(Residence in Baltimore: No. 2236 Lanvale St.; 13 yrs., 4 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Child

6-DATE OF BIRTH, June 25, 1904
(Month) (Day) (Year)

7-AGE, 13 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Sheckell

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Martha Hyson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha Sheckell

(Address) 2236 E. Lanvale St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....

.....

..... (Duration).....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Wm. H. Smith M. D.
(Coroner.)

Oct 8, 1917, (Address) 17 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, November 7, 1917.

20-UNDERTAKER, Henry Hoeck Son — ADDRESS 1301 E Eager St

important. See instructions on back of certificate.

NOV 5 - 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9809

CERTIFICATE OF DEATH.

64 ✓ D 9809

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2232 N. Calvert St ST.; 12 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Glascock

(Residence in Baltimore: No. 2232 N. Calvert St. St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, February 24, 1855, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
62 yrs. 8 mos. 9 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Traveling 066
(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

13

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, William R. Glascock

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Adelaide Adams

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph C. Barker

(Address) 115 S. Gay St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 191 7, to Nov 3 191 7, that I saw h[illegible] alive on Nov 3 191 7, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. 1 mos. 29 ds.

CONTRIBUTORY (Secondary) High blood pressure

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) Wm J. Walsh M. D.

Nov 5, 191 7 (Address) 711 S. St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cemetery	11/6, 191 7
20-UNDERTAKER Henry W. Means & Son	ADDRESS 205 N Gay

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9810

CERTIFICATE OF DEATH.

92 D 9810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 N Bond ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E Riess

(Residence in Baltimore: No. 1133 N. Bond St.; 1 yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 2nd, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Riess

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth Passagno

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Riess

(Address) 1133 N. Bond St

15-

Filed....., 191.....
Registrar.

NOV 6 - 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1 1917, to November 5 1917, that I saw h[illegible] alive on November 5 1917, and that death occurred, on the date stated above, at 4.6 m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jas. L. Valentine M. D.

November 5, 1917. (Address) 104 Dr. Knapp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Nov. 6th, 1917.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 Madison Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 9811

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 E Cross ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. W. Jones

(Residence in Baltimore: No. 103 E Cross St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 11, 1843
(Month) (Day) (Year)

7-AGE, 74 yrs. 1 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country) Rochester Co Mass

PARENTS.

10-NAME OF FATHER, Thomas Jones

11-BIRTHPLACE OF FATHER (State or Country), Rochester Co Mass

12-MAIDEN NAME OF MOTHER Rose C Jones

13-BIRTHPLACE OF MOTHER (State or Country), Rochester Co Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. W. Jones

(Address) 103 E Cross St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1917, to Nov 3 1917, that I saw h[illegible] alive on Nov 3 1917, and that death occurred, on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Clinical

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas A Schaefer M. D.

Nov 5, 191[illegible] (Address) 2013 W. Fratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, LOUDON PARK

DATE OF BURIAL, NOV 6 1917

20-UNDERTAKER ARMSTRONG-DENNY CO

ADDRESS 716 E Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9812

CERTIFICATE OF DEATH.

D 9812

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1509 Pr 36 ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth Ann Dilcoat

(Residence in Baltimore: No. 1509 Pr. 36th st. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 14 (Month) (Day) 1845 (Year)

7-AGE, 72 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, David Shipley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Ann Rhodes

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David E Dilcoat

(Address) 1509 Pr 36th

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3rd, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31st 1917, to Nov 3rd 1917, that I saw her alive on Nov 2nd 1917, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Adam Duncan M. D.

Nov 4, 191.7 (Address) 846 W 36 st Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Edmonds & Son — ADDRESS 367 Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9813

CERTIFICATE OF DEATH.

X81

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Hutchew

(Residence in Baltimore: No. Univ Hospt St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, ——— (Month) ——— (Day) 1816 (Year)

7-AGE, 101 yrs. —— mos. —— ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

243

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos Hutchew

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Celia Davis

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 26 1917, to Oct 28 1917, that I saw h in alive on Oct 28 1917, and that death occurred, on the date stated above, at 10 20 Pm.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration,

.....

.....

..... (Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrh & cirrh of liver, Cirrh

Aneurysm, (Duration) about 6 mo yrs. mos. ds.

(Signed) B. H. Brumbaugh M. D.

Oct 28 1917. (Address) Univ Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State unknown yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown.

Former or usual residence Glencoe Md.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, NOV. 5 1917

20-UNDERTAKER ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND
NOV 5 - 1917
Property of the Medical Library

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9811

CERTIFICATE OF DEATH.

1795 D 9811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel M. Dobbs

(Residence in Baltimore: No. 617 Bradley St

St.; —yrs., —mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown 1851
(Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tobacco
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed ....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 19 1917, to Nov. 7 1917, that I saw h alive on Nov. 2 1917, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma Bronchus Ca
Broncho Stasis

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. 2 mos. ds.

(Signed) Wm E Cleveland M. D.

11/7, 1917. (Address) University Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 25 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 617 Bradley St.

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, NOV 5 - 1917, 191...

20-UNDERTAKER Commissioner Health — ADDRESS

Per. Wm. E. WOODARD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9815

CERTIFICATE OF DEATH.

79 D 9815

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Collins

(Residence in Baltimore: No. 2 Murray's Court St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, January 18, 1869
(Month) (Day) (Year)

7-AGE, 48 yrs. 9 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General 04 D
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer

24 3

9-BIRTHPLACE, (State or Country), Rhode Island

PARENTS.

10-NAME OF FATHER, Joseph Collins

11-BIRTHPLACE OF FATHER (State or Country), Rhode Island.

12-MAIDEN NAME OF MOTHER Charlotte Gidley.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Conmed

(Address) Maryland Penitentiary

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May - 8 191 7, to October - 28 191 7, that I saw h... alive on October - 28 191 7, and that death occurred, on the date stated above, at 11.10 A. m.

The CAUSE OF DEATH* was as follows:

Edema, Endocarditis - Infectio... Endocarditis - General Anasarca... Chronic Endocarditis - Infectio...

..... (Duration) ....yrs. ....mos. 1/2 ds.

CONTRIBUTORY (Secondary) Edema, Endocarditis...

..... (Duration) ....yrs. 5 mos. ....ds.

(Signed) William H. Stewart M. D.

Oct 29, 1917 (Address) Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 6 mos. 11 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 2 Murray Court.

19-PLACE OF BURIAL OR REMOVAL, Johns Hopkins Hospital

DATE OF BURIAL, NOV 5 - 1917, 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

Wm. E. Vogler

Spec.—5-19-13—M. & T.—500 Bks.

D 9816

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 9816

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 W. Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia E. Hanneman Hanneman

(Residence in Baltimore: No. 1030 W. Franklin St. St.: Balt)

(If non-resident give usual residence.)

(... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 7th, 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. 7 mos. 25 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William P. Elder

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Rehling

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Elder

(Address) 1030 W. Franklin

15-

Filed ..... 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 2nd, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15th 1917, to November 2nd 1917, that I saw her alive on November 2nd 1917, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jennie K. Boyne M. D.

Nov. 3rd 1917. (Address) 1223 E. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Nov. 6th 1917.

20-UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9817.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9817.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Madison Ave, ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rob Boulding

(Residence in Baltimore: No. 417 Park St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) ..... (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer), Grocer

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Boulding

(Address) 417 East St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3d, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1917, to Nov 3d 1917
that I saw h— alive on Nov 3d 1917
and that death occurred, on the date stated above, at 7.30 a.m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of the Heart
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Organic Heart
Trouble (Duration) 2 yrs. ..... mos. ..... ds.
(Signed) A. Lee Elliott M. D.
11/3, 191.. (Address) 927 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem — DATE OF BURIAL, Nov 7, 1917

20-UNDERTAKER Mrs R A Elliott — ADDRESS 506 East St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9818

CERTIFICATE OF DEATH.

X 74

D 9818

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J. Mueller

(Residence in Baltimore: No. 1118 Dalya [illegible] Hospital St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 12 (Month) (Day), 1912 (Year)

7-AGE, 5 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Penn Yan N. Y.

PARENTS.

10-NAME OF FATHER, J. F. Mueller

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Florence Pratt

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Kirk

(Address) J. H. Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18 1917, to Nov. 4 1917, that I saw him alive on Nov. 4 1917, and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Davis M. D.

Nov. 5, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Penn. Yan, N. Y.

19-PLACE OF BURIAL OR REMOVAL, Penn Yan N. Y. DATE OF BURIAL, Nov. 6, 1917.

20-UNDERTAKER Edward C. Fuller ADDRESS 221 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9819

CERTIFICATE OF DEATH.

30 D 9819

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Boyle ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erma Scheeler

(Residence in Baltimore: No. 1504 Boyle St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sep. (Month) 3 (Day) 1913 (Year)

7-AGE, 4 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John E Scheeler

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Emma Cole

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Scheeler

(Address) 1504 Boyle

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26 1917, to Nov 3 1917, that I saw h er alive on Nov 3 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) .....yrs. .....mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) .....yrs. .....mos. .....ds.

(Signed) Jas A O Daniel M. D.

Nov 5, 1917. (Address) 107 E Mulb

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery — DATE OF BURIAL, Nov 6, 1917.

20-UNDERTAKER E J Fanning — ADDRESS 1460 Bolton

Spec.—8-24-14—M. & T.—2000 Bks.

D 9820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9820

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 17 S. Wolfe St. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Schmitt

(Residence in Baltimore: No. 17 S Wolfe St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, March 4, 1845 (Month) (Day) (Year)

7-AGE, 71 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Peter Schmitt.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Schuler

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Grusse

(Address) 718 S. 4th St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3rd, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1917, to Nov 3 1917, that I saw him alive on Nov 3 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis - Pulmonary Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Clark M. D.

Nov 5, 1917. (Address) 1105 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	Nov. 6th, 1917.
20-UNDERTAKER	ADDRESS
Lilly & Fuhr	103 E Hoffman

(See instructions on back of certificate.)

Spec.—8-24-14—M. & T.—2000 Bks.

D 9821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9821

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth S. Knabel

(Residence in Baltimore: No. 1407 Orleans St West St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, August 17, 1882
(Month) (Day) (Year)

7-AGE, 70 yrs. 2 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry J. Knabe

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth S. Funkhouser

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Hunt

(Address) Halethorpe Md

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 3 1917, that I saw her alive on Nov 3 1917, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas B. Hall M. D.

Nov 3, 191.. (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State 35 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1407 West Ostend St

Former or usual residence 1407 West Ostend

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Nov 6, 191..
20-UNDERTAKER	ADDRESS
William Cook	502 E North Ave.

Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9822

HEALTH DEPARTMENT—CITY OF BALTIMORE

X79 ✓ D 9822

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Williams

(Residence in Baltimore: No. Camp Meade St.; ...yrs., 3 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Negro	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1885 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. ... mos. ... ds.	... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Florida

PARENTS.

10-NAME OF FATHER, Dont Known

11-BIRTHPLACE OF FATHER (State or Country), Dont Known

12-MAIDEN NAME OF MOTHER Dont Known

13-BIRTHPLACE OF MOTHER (State or Country), Dont Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E E Stern

(Address) Camp Meade A.A. Camp H

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 31 1917, to Nov. 2 1917, that I saw him alive on Nov. 2 1917, and that death occurred, on the date stated above, at 12:25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Not diagnosed

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. G. A. Corpening M. D.

11-2, 1917 (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State Unknown yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Camp Meade Md.

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Nov. 6, 1917
20-UNDERTAKER	ADDRESS
Wilmain Cook	507 E North

(If not buried in Baltimore, give name of cemetery or crematory.)

(Fill out all blanks on back of certificate.)

Spec.—8-24-14—M. & T.—2000 Bks.

D 9823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9823

CERTIFICATE OF DEATH.

×49

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Potomac ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beulah Evelyn Snyder

(Residence in Baltimore: No. 140 N. Potomac St.; ~ yrs., 3 mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, September 6, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 1 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Hagerstown Md.

PARENTS.

10-NAME OF FATHER, George W. Snyder

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ella Cramer

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Snyder

(Address) 140 N. Potomac St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Nov 4 1917, that I saw h[illegible] alive on Nov 4 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

(Signed) John G. Cramer M. D.

Nov 6, 1917. (Address) Summit Ave & Potomac St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 3 mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Frederick City

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Nov. 6, 1917.

20-UNDERTAKER	ADDRESS
H E Hughes	17 S. Broadway

NOV 5 - 1917

USE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9821

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 ✓ D 9821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Adaline Stitely

(Residence in Baltimore: No. 1532 W Lanvale St.: 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, ... July (Month) 28 (Day), 1827 (Year)

7-AGE, 90 yrs. 3 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home work.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Stitely

(Address) 612 Lemmon St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Nov 5 1917, that I saw h[illegible] alive on Nov 5 1917, and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

.....

.....

..... (Duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) yrs. ..... mos. ..... ds.

(Signed) W. J. Bergenhough M. D.

Nov 5, 1917 (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. 3 mos. 4 ds. In the State 10 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1532 Lanvale St

19-PLACE OF BURIAL, OR REMOVAL. Woodmansee Md

DATE OF BURIAL. Nov 8, 1917

20-UNDERTAKER W M Routson

ADDRESS 2301 Greene

Spec.—8-24-14—M. & T.—2000 Bks.

D 9825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO. D 9825

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Odeny ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Siver

(Residence in Baltimore: No. 815 N. Ostend St.; ... yrs., 6 mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	Colored	Widowed

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 60 yrs. ... mos. ... da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ... 000

000

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie Johnson

(Address) 815 N. Ostend

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 191., to Nov 6 191., that I saw her alive on Nov 3 191. and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

(a) Labor Incarcerated

(Duration) ... yrs. ... mos. 3 da.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... da.

(Signed) F. Cohen Lurie M. D.

..., 191... (Address) 710 Eig 1101

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn St	Nov 6, 191...
20-UNDERTAKER	ADDRESS
C. W. Brown & Son	

(SEE INSTRUCTIONS ON BACK OF CERTIFICATE.)

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9826

CERTIFICATE OF DEATH.

64 ✓ D 9826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 McCulloh ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Brown

(Residence in Baltimore: No. 1903 McCulloh St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... 021

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Samuel Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... George Brown

(Address)..... 1903 McCulloh

15-

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Nov 3 1917, that I saw h[illegible] alive on Nov 3 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

.....

Cerebral Apoplexy

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Arteric Sclerosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H S McCard M. D.

11/14, 191.7. (Address) 200 S Wm St Hillar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Union Bridge Carroll Co DATE OF BURIAL, Nov 6, 1917

20-UNDERTAKER Md ADDRESS Edward Ringgold 1463 N Carey

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9827

CERTIFICATE OF DEATH.

61 AD 9827

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 George St ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME George Washington

(Residence in Baltimore: No. 819 George St St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 640

24 3

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Washington

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susie Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Berska Washington

(Address) 819 George St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov - 3rd, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/1 191 , to 11/3 191 , that I saw him alive on 11/1 191 , and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

(Cardiac Asthma)

(Cerebro Spinal Meningitis)

(Epidemic) (Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) Benj R Lantz M. D.

11/3, 191 (Address) 7136 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Nov 5 1917

20-UNDERTAKER Samuel Handy

ADDRESS 578 W Balto

Important. See instructions on back of certificate.

D 9828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 9828

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 710 S. Bond ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Trentowski

(Residence in Baltimore: No. 710 S Bond St.; yrs., 1 mos. 7 ds.)

PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 29 (Day), 1916 (Year)

7-AGE, 1 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Anthony Trentowski

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Frances Dreyka

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Trentowski

(Address) 710 S Bond

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ... yrs. ... mos. ... ds.

(Signed) Clement Tyson Coroner M. D.

Nov 6, 1917 (Address) 1600 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov 8, 1917

20-UNDERTAKER Wm Frackowiak ADDRESS 1615 East

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9829 — 28 V D 9829

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 524 Bloom ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennett T Gouldsmough

(Residence in Baltimore: No. 524 Bloom St.; Lyttle mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 27 (Day) 1880 (Year)

7-AGE, 37 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Berry

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary A Frank's

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R Goldsborough

(Address) 524 Bloom St

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/21 1917, to 11/4 1917, that I saw h[illegible] alive on 11/4 1917, and that death occurred, on the date stated above, at 7 40 m.

The CAUSE OF DEATH* was as follows:

Phthisis

Pulmonary

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) T. Houston

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11/5, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon

DATE OF BURIAL, Nov 6th, 191.7

20-UNDERTAKER Clarence E Dwyer

ADDRESS 1364 Mary

Important: See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9830 — 15-IV — D 9830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. Nursery & Childs Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Schmidt

(Residence in Baltimore: No. Nursery & Childs Hosp. St.; ..yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	single

6-DATE OF BIRTH, Sept. 5th, 1917. (Month) (Day) (Year)

7-AGE, ..yrs. 1 mos. 29 ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Stephen Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Fantsich

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. T. La Roe

(Address) Nursery & Childs Hosp.

15- Filed Nov 6 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 3, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Nov 3 1917, that I saw him alive on Nov 3 1917, and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..yrs. 2 mos. ..ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..yrs. .. mos. ..ds.

(Signed) Harry Goldberg M. D.

11/5, 191.7 (Address) 2031 W Fratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 7 ds. In the State yrs. 2 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Nursery & Childs Hospital

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Harry W Fitzke — ADDRESS 153 W Lombard St

Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9831

CERTIFICATE OF DEATH.

79 ✓ D 9831

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5737 N Carrollton Av St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Bauer

(Residence in Baltimore: No. 5737 N Carrollton Av St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, January (Month) 2 (Day) 1878 (Year)

7-AGE, 38 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer) 172

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo A Bauer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Amanda Dorr

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward W Bauer

(Address) 4003 Gorsuch Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1917, to Nov 3 1917, that I saw h[illegible] alive on " 3 1917, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Acute dilatation Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) F J Kirby M. D.

Nov 3, 191 7 (Address) 110 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL. 11-7-, 191 7

20-UNDERTAKER H Brauning & Son

ADDRESS 517 W. Edmondson St

(Instructions on back of certificate.)

Spec.—8-24-14—M. & T.—2000 Bks.

D 9832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9832

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 788 Franklin St. 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert L Gibbs

(Residence in Baltimore: No. 788 Franklin St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) — (Day) 1 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Porter 086

(b) General nature of industry, business, or establishment in which employed (or employer) Porter in Hotel

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Robert H Gibbs

11-BIRTHPLACE OF FATHER (State or Country), in Va

12-MAIDEN NAME OF MOTHER Ann L Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Webster his Sister

(Address) 788 N Fulbrug ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3 (Month) (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191.., to Nov 3 191.., that I saw h.. alive on Nov 3 191.., and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..yrs. ..mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(Duration) ..yrs. ..mos. 1 ds.

(Signed) Chas T Chandler M. D.

Nov 5, 191.. (Address) 1504 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laural Cem

DATE OF BURIAL, Nov 7, 1917

20-UNDERTAKER Wm R Elliott

ADDRESS 900 E Fayette

Important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 9833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Nwd ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Johnson

(Residence in Baltimore: No. 421 West St

St.; ✓ yrs., ✓ mos. ✓ ds.)

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Wid

6-DATE OF BIRTH, June (Month) 19 (Day), 1877 (Year)

7-AGE, 40 yrs. 3 mos. 16 ds. If LESS than 1 day, ✓ hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... ✓ 054

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ✓ Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER ✓ Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H Lute

(Address) 421 nwd st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 4 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Nov 4 1917, that I saw h.r alive on Nov 1 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. ✓ ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

..... (Duration) ✓ yrs. ..... mos. 10 ds.

(Signed) D S Grewell M. D.

11-5....., 1917. (Address) 707 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 7., 191...
20-UNDERTAKER	**ADDRESS**
Edward Ringgold	1403 N Carey

Spec.—8-24-14—M. & T.—2000 Bks.

D 9331 ✓ D 9331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 720 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Ockrell

(Residence in Baltimore: No. 533 & 535 Lucky St City St.; 5 yrs., 3 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colred	Single

6-DATE OF BIRTH, July 5, 1912
(Month) (Day) (Year)

7-AGE, 5 yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

000

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... T. Ricks .....

(Address)..... J. H. Hospital .....

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Nov. 4 1917, that I saw h.. alive on Nov. 4 1917, and that death occurred, on the date stated above, at 8:15 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

..... (Duration)...yrs...mos. 14 ds.

CONTRIBUTORY (Secondary) Tuberculosis, pulmonary

..... (Duration)...yrs. 2 mos...ds.

(Signed) F. M. Rivers M. D.

Nov. 5, 1917. (Address) Johns Hopk. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~ yrs. ~ mos. 4 ds. In the State ~ yrs. ~ mos. ~ ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 533 & 535 Lucky St. City

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 6, 1917.

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 N Bond

Important. See instructions on back of certificate. Every statement of OCCUPATION is very

D 9835 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9835

CERTIFICATE OF DEATH.

Registered No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 402 Pinkney Pl. St.; 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth J. Ellwood

(Residence in Baltimore: No. 402 Pinkney Place St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, November 1 1847
(Month) (Day) (Year)

7-AGE, 69 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Dalls Co Md

PARENTS.

10-NAME OF FATHER, John Ellwood

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Gardner

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Medairy

(Address) 402 Pinkney pl

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) [illegible]
(Coroner.) M. D.

Nov 4, 191.., (Address) 1639 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery. DATE OF BURIAL, Nov. 8, 1917

20-UNDERTAKER E. A. Stadfeld Jr. ADDRESS 2113 Gunnor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

D 9836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 9836

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1610 W Mulberry St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Coulter

(Residence in Baltimore: No. 1610 W Mulberry St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	widow

6-DATE OF BIRTH. Sept 30, 1853
(Month) (Day) (Year)

7-AGE. 64 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. Thomas Hays

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mary Newman

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Fowler

(Address) 1618 W Mulberry

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Congestive Chill

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Coronary Artery

(Duration) yrs. mos. ds.

(Signed) James M Fowler M. D.
(Coroner)

Nov 5, 1917. (Address) 707 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Washington D.C.

DATE OF BURIAL. Nov 7, 1917

20-UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Frieda Pregrave.

11

D 9837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 9837

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 904 McCulloughST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frieda Pregrave

(Residence in Baltimore: No. 904 McCulloughSt.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) 7-Sept (Day), 1897 (Year)

7-AGE, 20 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country), Wisconsin

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Wisconsin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Husband

(Address) 904 McCulloughSt.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Coma
..... Cerebral Hemorrhage
..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Unknown

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Nov. 5, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Luray Va

DATE OF BURIAL, Nov. 7, 1917

20-UNDERTAKER Chas. E. Branch

ADDRESS 801 Madison Av

NOV 6 1917 Burial Permit Given

Burial Fee not Given

Filed in the Health Department of Baltimore, Md., in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9838

CERTIFICATE OF DEATH.

175

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Nigh Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J Geiss.

(Residence in Baltimore: No. 1308 Homewood Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, March 12, 1851
(Month) (Day) (Year)

7-AGE, 66 yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 080

492

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A Geiss

(Address) 1308 Homewood

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said None
(Inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism, fractured leg, shock

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Mc Donald M. D.
(Coroner.)

Nov 6, 1917. (Address) 411 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 hours yrs. mos. ds. In the State 66 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Bolton Cem

DATE OF BURIAL, Nov 7, 1917

20-UNDERTAKER John Herwig & Co

ADDRESS 2008 Adams

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9839

CERTIFICATE OF DEATH.

64 N

D 9839

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. 2923 Hudson ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Maher

(Residence in Baltimore: No. 2923 Hudson St.: 66 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Custom House
(b) General nature of industry, business, or establishment in which employed (or employer): Weigher 086

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Maher

(Address) 2923 Hudson St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 191 6, to Nov 3 191 7, that I saw him alive on Nov 1 191 7, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. McAuley M. D.

Nov 3, 191 7 (Address) 1395 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery — DATE OF BURIAL, Nov 7, 191 7.

20-UNDERTAKER Christian Miller — ADDRESS 2334 Jefferson St

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9840

CERTIFICATE OF DEATH.

154 D 9840

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Ashland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Schultheis

(Residence in Baltimore: No. 2300 Ashland Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... Aug 1 ....., 1836
(Month) (Day) (Year)

7-AGE, ... 81 ..... yrs. ..... 2 ..... mos. ..... 3 ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Farmer .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Greunfelder

(Address) 817 N. Bradford st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 4 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Nov 4 1917, that I saw h~~e~~ alive on Nov 4 1917, and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

..... Infirmities Of .....
..... Old Age .....
..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ..... Exhaustion .....
..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... R. E. Campbell ..... M. D.

Nov 4, 1917 (Address) 1647 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Emmanuel Cemetery	Nov 7, 1917
20-UNDERTAKER	**ADDRESS**
Christian Miller	2320 Jefferson st

IMPORTANT. See instructions on back of certificate.

NOV 7 - 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9811

CERTIFICATE OF DEATH.

8D 9811

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Harlem ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Katherine Hessel

(Residence in Baltimore: No. 1524 Harlem ave St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem. | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct. (Month) 13 (Day) 1839 (Year)

7-AGE, 77 yrs. ..... mos. 20 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Enoch Miller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maria Bell

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kl. C. Hessel

(Address) 2600 E Baltimore

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1916, to Nov. 4 1917, that I saw h.. alive on 11 11 1916, and that death occurred, on the date stated above, at 7 44 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary .....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) C. C. Hessel M. D.

11/6/17, 191.7. (Address) 2600 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetary | DATE OF BURIAL, Nov. 8, 1917.

20-UNDERTAKER Christian Miller | ADDRESS 2334 Jefferson St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 9842

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Hayes

(Residence in Baltimore: No. Frederick & Lexington Sts St.: ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 47 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Thos. Hayes

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Carroll

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Resident Mercy Hosp

(Address) Calvert St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Nov 6 1917, that I saw h[illegible] alive on Nov 6 1917, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Clinical Signs
(Duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Not Ascertained
(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Edward J. Lynch M. D.

11/6, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 17 ds. In the State 47 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Frederick & Lexington Sts

Former or usual residence Frederick & Lexington Sts

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemy	11/7, 1917

20-UNDERTAKER Henry W. Meade & Son ADDRESS 1025 E. Baltimore

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9813

CERTIFICATE OF DEATH.

17 D 9813

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 West Fayette St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Francis Morton

(Residence in Baltimore: No. 837 West ~~Francis Jordon~~ Fayette St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) widow

6-DATE OF BIRTH, 2nd (Month) 16th (Day) 1821 (Year)

7-AGE, 96 yrs. 8 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) own

9-BIRTHPLACE, (State or Country), Cumberland Co Va

PARENTS.

10-NAME OF FATHER, Col Wm Thamp

11-BIRTHPLACE OF FATHER (State or Country) Charlotte Co, Va

12-MAIDEN NAME OF MOTHER Elizabeth Jordon

13-BIRTHPLACE OF MOTHER (State or Country), do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha F Morton

(Address) 837 West Fayette St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11th (Month) 5th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1917, to Nov 5th 1917, that I saw her alive on Nov 5th 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

Last sickness about one week

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken hip which occurred in April 1917

(Duration) yrs. mos. ds.

(Signed) H. T. Morse M. D.

....., 191... (Address) 1925 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hernwell Va

DATE OF BURIAL, Nov 7, 1917

20-UNDERTAKER W. Maurice Poulton

ADDRESS 2307 Druid

NOV 7 - 1917 ROBERT B. KRAUTER Burial Permit

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9811

CERTIFICATE OF DEATH.

1920 D 9811

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 n. Dallas st ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly May Croma

(Residence in Baltimore: No. 1820 n Dallas st — St.; ..... yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH. ....., ..., 1 (Month) (Day) (Year)

7-AGE. 26 years ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... Wife

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, W. Ennings

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lilly Croma

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Croma

(Address) 1820 n Dallas st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 1, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Nov 4 1917, that I saw her alive on Nov 4 1917, and that death occurred, on the date stated above, at 11:46 m.

The CAUSE OF DEATH* was as follows: Chronic Brights Disease

Abt (Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (Duration) 2 yrs. 6 mos. ds.

(Signed) [illegible] M. D.

Nov 5 th, 191 7 (Address) 2100 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Wood Lawn Cemetery

DATE OF BURIAL, Nov 7th, 191..

20-UNDERTAKER George J. Reuter

ADDRESS 1735 Hanford Ave

Important. See instructions on back of certificate.

...OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

W-2810 M 120c

D 9815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1254 Bannum ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Albert Bohnert

(Residence in Baltimore: No. 1254 Bannum St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Bohnert.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dora Knorr

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bohnert

(Address) 1254 Bannum ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 191 7, to Nov 4 191 7, that I saw h alive on Nov 4 191 7, and that death occurred, on the date stated above, at 2.50 m.

The CAUSE OF DEATH* was as follows:

Chronic

Ca Pharynx and Larynx

Hepatitis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 4, 1917 (Address) 2311 Hanford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Mathews Cemetery	Nov 7, 1917
20-UNDERTAKER	ADDRESS
Geo. J. Roth	1735 Harford ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9816

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Argyle ave. St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Williams

(Residence in Baltimore: No. 1436 Argyle ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 097

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robt. Dewkett.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Flora —

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cantrin Williams

(Address) 1436 Argyle ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25th 1917, to Nov. 4th 1917, that I saw h— alive on Nov. 3d 1917, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Following Influenza

(Duration) yrs. mos. ds.

(Signed) H. [illegible] M. D.

Nov. 4th, 191.. (Address) 924 Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bowie Md. DATE OF BURIAL, Nov. 7, 191.7.

20-UNDERTAKER Samuel Handley ADDRESS 5 [illegible] Fulton

Important. See instructions on back of certificate.

Washington Makel

D 9817.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1629 Brown ST. 15 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Washington Makel

(Residence in Baltimore: No. 1629 N. Brown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colo

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 4, 1858
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Abraham Makel

11-BIRTHPLACE OF FATHER (State or Country), Ma. Not.

12-MAIDEN NAME OF MOTHER, Isabella Blake

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs

(Address) 1629 N. Brown

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 4, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. W. Colton M. D.
(Coroner)

....., 191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State None yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cemty

DATE OF BURIAL, Nov. 7 19 17

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9818

CERTIFICATE OF DEATH.

10 D 9818

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Geo. Kates

(Residence in Baltimore: No. 3754 Hickory Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. Nov 28, 1885
(Month) (Day) (Year)

7-AGE. 31 yrs. 11 mos. (ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Geo Kates

11-BIRTHPLACE OF FATHER (State or Country). New Jersey

12-MAIDEN NAME OF MOTHER Mary Livingston

13-BIRTHPLACE OF MOTHER (State or Country). Ireland Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice Kates

(Address) 3754 Hickory Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1917, to Nov 4 1917, that I saw h alive on Nov 4 1917, and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Postoperative Hemorrhage

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(Duration) 3 yrs. mos. ds.

(Signed) W J Eyerman M. D.

Nov 4., 191 7. (Address) St Jos Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Balt Md

Former or usual residence 3754 Hickory Ave

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet DATE OF BURIAL, Nov 7, 191..

20-UNDERTAKER A S Marshall ADDRESS 3309 Falls Rd

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9819

CERTIFICATE OF DEATH.

28

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3950 Falls Road ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick N. Ruff

(Residence in Baltimore: No. 3950 Falls Road St.; ....yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. June (Month) 19 (Day), 1892 (Year)

7-AGE. 25 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Special Agent
(b) General nature of Industry, business, or establishment in which employed (or employer): Pa. Ry.

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER. Elden Ruff

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co. Md

12-MAIDEN NAME OF MOTHER Fannie L. Schutz

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Elden Ruff
(Address) 3950 Falls Road

15-
Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1917, to Nov 6 1917, that I saw him alive on Nov 6 1917, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) S R Watts M. D.

Nov 6, 1917. (Address) 365 W 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Nov. 8'th. 1917

20-UNDERTAKER A.S. Marshall ADDRESS 3539 Falls Road

Important. See instructions on back of certificate. Every statement of OCCUPATION is very

Margaret E. Burrier

D 9850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital St. 11 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E Burrier,

(Residence in Baltimore: No. 621 Barkley Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, ... March ..... 8 ....., 1838
(Month) (Day) (Year)

7-AGE, ... 79 ..... yrs. ..... 6 ..... mos. ..... 26 ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework,
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Wallace,

11-BIRTHPLACE OF FATHER (State or Country). Scotland,

12-MAIDEN NAME OF MOTHER Eachan Cockron

13-BIRTHPLACE OF MOTHER (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cuckow

(Address) 180 N Gay St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov ..... 4 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Left
Hemiplegia, Complete

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Nov 6, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. 14 ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....
.....621 N Broadway.....

Former or usual residence.....621 N Broadway.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemy	Nov 7, 1917
20-UNDERTAKER	ADDRESS
Albert E Fuller	221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9851

28 D 9851

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 E Chase ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia M Farrelly

(Residence in Baltimore: No. 932 E. Chase St.: 25 yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. 4, 1891
(Month) (Day) (Year)

7-AGE, 25 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Michael J. Farrelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret McCabe

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Michael J. Farrelly

(Address) 932 E Chase St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Nov 5 1917, that I saw h- alive on Nov 5 1917, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward H Watrous M. D.

Nov 6, 1917. (Address) 2412 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Nov 8, 1917.

20-UNDERTAKER	ADDRESS
Henry Hosch & Son	1301 E Eager St

important. See instructions on back of certificate.

D 9852 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9852

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hamad Heird

(Residence in Baltimore: No. 2709 Huntington St.: Yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	colored	boy

6-DATE OF BIRTH March 1 (Month) 18 (Day), 1907 (Year)

7-AGE 10 yrs. 7 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): boy, 040

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Walter Heird

11-BIRTHPLACE OF FATHER (State or Country): Washington

12-MAIDEN NAME OF MOTHER: Maggie Wilson

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Heird

(Address) 2709 Huntington ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia, which
Lay Street car conductor
4 years 2709 Huntington ave
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Jackson (Coroner) M. D.

June 7, 1917 (Address) 1 W. Lee St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL, June 9, 1917

20-UNDERTAKER: Josiah Lee ADDRESS 400 W Saratoga ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9853

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1152 E. Lombard St. 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Usriel Wolman

(Residence in Baltimore: No. 1152 E Lombard St St.: 16 yrs., ... mos. ... ds.)

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
72 yrs. ... mos. ... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sexton 088
(b) General nature of industry, business, or establishment in which employed (or employer)..... Congregation 835

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Simon

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rivka

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin

(Address) 1411 E Baltimore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Nov 6 1917, that I saw him alive on Nov 6 1917, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

..... (Duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) ... yrs. ... mos. 3 ds.

(Signed) Herman Seidel M. D.

Nov. 6, 1917. (Address) 1931 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herman Run	11/7, 191...

20-UNDERTAKER	ADDRESS
Josh Levin	1411 E Balt

Spec.—8-24-14—M. & T.—2000 Bks.

D 9851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9851

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Desela

(Residence in Baltimore: No. 742 N. Kenwood ave St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH. Dec. (Month) 5 (Day), 1897 (Year)

7-AGE. 19 yrs. 11 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Sikecka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Anna Charvale

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Desela

(Address) 742 N. Kenwood ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6th 1917, to November 6th 1917, that I saw h-e alive on November 6th 1917, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Synovitis fever

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Ernest M. Gallagher M. D.

Nov. 14th, 1917. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem. DATE OF BURIAL, Nov. 8, 1917

20-UNDERTAKER, Jos J. Kerr ADDRESS 156 N. Luzerne ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 N. Eutaw St. ST.; 11 WARD) REGISTERED No. C

2-FULL NAME Mary E. Scruggs.

(Residence in Baltimore: No. 842 N. Eutaw St St.; 70 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed.

6-DATE OF BIRTH, July (Month) 1st (Day), 1853 (Year)

7-AGE, 64 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) House work

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Keane.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Sarah Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Agatha C. Berger

(Address) 842 N. Eutaw St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1st 1917, to Nov 6th 1917, that I saw h[illegible] alive on November 5th 1917, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

(Central Hemorrhage with Right Hemiplegia)

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Arteriosclerosis

(Duration) 10 yrs. ....mos. ....ds.

(Signed) Wilmer Brinton M. D.

Nov 7th, 1917 (Address) Calvert Building

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem

DATE OF BURIAL, Nov 8th, 1917

20-UNDERTAKER Benjamin Kees Son Co

ADDRESS 3 Caldwell Sq

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9856

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Bruckner

(Residence in Baltimore: No. 2422 Foster av. St.; 23 yrs. 2 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. 9th, 1894
(Month) (Day) (Year)

7-AGE, 23 yrs. 2 mon. 26 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 109

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Brueckner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katharine Lossman

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine Brueckner

(Address) 2422 Foster Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4 1917, to Nov. 5 1917, that I saw h[illegible] alive on Nov. 5 1917, and that death occurred, on the date stated above, at 6[illegible] A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 4 yrs. ....mos. ....ds.

(Signed) Edward P. Smith M. D.

Nov 5, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 10½ mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 2422 Foster Av.

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cemetery — DATE OF BURIAL, Nov. 8, 1917.

20-UNDERTAKER Lilly & Geiler — ADDRESS 403 S. Mo[illegible]

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9857.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9857.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S Kenwood ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Haupert Sunter

(Residence in Baltimore: No. 519 S Kenwood ave St.) Life 1 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, July (Month) 4 (Day), 1917 (Year)

7-AGE, ... yrs. 4 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Sunter

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Heber

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Sunter

(Address) 519 S Kenwood ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4th 1917, to Nov 6th 1917, that I saw h[illegible] alive on Nov 6th 1917, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) John Gilbert Miller M. D.

11/6, 1917. (Address) 2737 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Emanuels Cem	Nov 9, 1917
20-UNDERTAKER	ADDRESS
Louis Heemann	3[illegible] Broadway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9858

CERTIFICATE OF DEATH.

80 D 9858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Charles St. Corner Centre St.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick P. Ross

(Residence in Baltimore: No. Buckler Apartment Chas. & Centre; 58 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Unknown 1 .....
(Month) (Day) (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Atty at Law
(b) General nature of industry, business, or establishment in which employed (or employer) 042

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Dr. Ross

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Jane Clendenin

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. N. L. Dashiell

(Address) 2927 St Paul St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Nov. 6 1917, that I saw h[illegible] alive on Nov 6 1917, and that death occurred, on the date stated above, at 6.35 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis & Angina Pectoris

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) [signature] M. D.

Nov. 7, 191.7 (Address) 5 E Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Nov. 8, 191.7

20-UNDERTAKER John O. Mitchell — ADDRESS 1200 N. Fayette

important. See instructions on back of certificate.

D 9859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hut Conway 600 block West (east) St.; 4 WARD)

REGISTERED NO. C 56

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Dewane, Dewane

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	unknown

6-DATE OF BIRTH, ... Unknown 1 .....
(Month) (Day) (Year)

7-AGE, about 68 yrs. 68 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087

3 463

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Police Dept.

(Address) .....

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 1 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Accidental .....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Fract. femur .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 2, 191.7 (Address) 165 Forrest

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cemetery	Jan 7, 1917.
20-UNDERTAKER W M Poulson	ADDRESS 230 N Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9860

HEALTH DEPARTMENT—CITY OF BALTIMORE

1222

D 9860

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 N. Carey ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward E. Johnson

(Residence in Baltimore: No. 329 N. Carey St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feby 9, 1874 (Month) (Day) (Year)

7-AGE 43 yrs. 8 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Helen Stanley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie E. Johnson

(Address) 329 N. Carey St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1917, to Nov 6 1917, that I saw h— alive on Nov 6 1917, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cyclo-Nephritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 1 ds.

(Signed) H. L. Lamar M. D.

11-7—, 191.7. (Address) 901 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Nov 9, 1917.

20-UNDERTAKER Chas. G. Black & Son — ADDRESS Northern Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9862

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 N. Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian P. Beatty

(Residence in Baltimore: No. 931 N. Stricker St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	widow

6-DATE OF BIRTH, ... Aug. (Month) 26 (Day), 1870 (Year)

7-AGE,	If LESS than 1 day,
47 yrs. 2 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Somerset Co. Md.

PARENTS.

10-NAME OF FATHER, Sydney L Newman

11-BIRTHPLACE OF FATHER (State or Country), Somerset Co. Md.

12-MAIDEN NAME OF MOTHER Virginia E Price

13-BIRTHPLACE OF MOTHER (State or Country), Somerset Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie E Newman

(Address) 931 N. Stricker St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1917, to Nov. 4 1917, that I saw her alive on Nov. 3 1917, and that death occurred, on the date stated above, at 8-30 a.m.

The CAUSE OF DEATH* was as follows:

.....

Bronchial Pneumonia

.....

..... (Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Carl Carstens M. D.

Nov. 4, 1917. (Address) 926 N. Stricker St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Vernon Cemetery Md.	Nov. 8., 1917.

20-UNDERTAKER	ADDRESS
W. J. Tuckwell Son	North Ave

important. See instructions on back of certificate.

If any of the items of this certificate may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D 9862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9862

CERTIFICATE OF DEATH.

X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 12 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Rose Taylor

(Residence in Baltimore: No. 327 N. Carey St.; — yrs., 4 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, October 18, 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. — mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 1037

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Joseph Rose Saunders

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Taylor

(Address) 327 N. Carey St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 7 1917, that I saw h.. alive on Nov 7 1917, and that death occurred, on the date stated above, at 8 39 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Hemorrhage due to Arteriosclerosis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. E. Cunningham M. D.

Nov 7, 1917 (Address) Franklin Square Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. X mos. 1 ds. In the State ....yrs. 4 mos. ....ds.

Where was disease contracted, if not at place of death? 327 N. Carey, Md.

Former or usual residence 327 N. Carey

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Clinton N. C.	Nov. 8, 1917
20-UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

important. See instructions on back of certificate.

D 9863 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 154 D 9863

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Little Sinter & Pear St., 10 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wright

(Residence in Baltimore: No. Little Sinter & Pear St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem.	Wht	Widow

6-DATE OF BIRTH, Unknown, 1 ..... (Month) (Day) (Year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House
(b) General nature of industry, business, or establishment in which employed (or employer) Home 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Baldwin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Sales Bryan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sales Bryan

(Address) Little Sinter & Pear

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

..... 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 3, 1917

20-UNDERTAKER H. C. Middefeld — ADDRESS 917 Fremont Ave.

D 9864

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 9864

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 717 W 34 St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine McKeire

(Residence in Baltimore: No. 717 W. 34 st St.; 35 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female.

4-COLOR OR RACE: white

5-~~SINGLE~~ MARRIED WIDOWED ~~OR DIVORCED~~ (Write the word): Widowed

6-DATE OF BIRTH: unknown. (Month) (Day), 1847. (Year)

7-AGE: about 70. yrs. mos. ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Ireland.

PARENTS

10-NAME OF FATHER: Thomas Lanahan.

11-BIRTHPLACE OF FATHER (State or country): Ireland.

12-MAIDEN NAME OF MOTHER: Mary Lanahan.

13-BIRTHPLACE OF MOTHER (State or country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary B. Coobahey.

(Address) 717 W. 34 St.

15-

Filed ....., 191 .....

REGISTRAR .....

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 7, 1917 (Month) (Day), (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7, 1917, to, ..., 191....., that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Congenital Senile

(Duration) yrs mos ds.

Contributory (SECONDARY) .....

(Duration) yrs mos ds.

(Signed) John J Morrissey M. D.

Nov 7 1917 [Address] 9632 Roland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Jacob. Texas Md.

DATE OF BURIAL: Nov 10, 1917

20-UNDERTAKER: Ellsworth & Son

ADDRESS: 967 Eastern Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9865

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3400. Chestnut Ave. (St.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D. Moore

(Residence in Baltimore: No. 3400. Chestnut Ave. St.; 75 yrs., 3 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH. July 10, 1842.
(Month) (Day) (Year)

7-AGE. 75 yrs. 3 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). Retired 218 015

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Barney Moore

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rachael S. Moore

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. D. Moore Jr.

(Address) 3400. Chestnut Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 6 1917, that I saw him alive on Nov 6 1917, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia Oedema

(Duration) ....yrs. ....mos. 1 ds.

(Signed) R. T. Norment M. D.

Nov 7, 191 7. (Address) 3347 Chestnut Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, Nov. 10., 1917.

20-UNDERTAKER Dunworth & Son — ADDRESS 361 Cathedral

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9866 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D 9866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Maggie Fry

(Residence in Baltimore: No. 2713 Hampden Ave St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Single

6-DATE OF BIRTH, ... unknown ....., 1875
(Month) (Day) (Year)

7-AGE, about 42 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None.
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank C Fry.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Toney.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Geo. Brown.

(Address) 2513 Ind Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November Sixth, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 21 1910, to November 6 1917, that I saw h ex alive on November 6 1917, and that death occurred, on the date stated above, at 4 20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebritis, Pneumonia and Myocardial Insufficiency

(Duration) 6 yrs. 11 mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H Hollister M. D.

Nov 6, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 11 mos. 15 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, Nov. 10, 1917

20-UNDERTAKER Ehrmantraut & Son ADDRESS 3617 Eastern Ave

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9867.

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 D 9867.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Barclay St. ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Mary Jones

(Residence in Baltimore: No. 3313 Barclay St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, August 16 th, 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Daniel Campbell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Harriett Pennell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Jones

(Address) 3313 Barclay St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 18th 1917, to Nov 6th 1917, that I saw her alive on Nov 5th 1917, and that death occurred, on the date stated above, at 1040 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Hypertrophy of Heart
.....
..... (Duration).....yrs.....mos...1...ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy
..... (Duration).....yrs...2...mos.....ds.

(Signed) Geo. M. Humerey M.D.

Nov 6th, 1917. (Address) 1537 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary's Cem	Nov 9, 1917.
20-UNDERTAKER Daniel Hanley	ADDRESS 578 W Baltimore

important. See instructions on back of certificate.

...rly classified. Exact statement of OCCUPATION is very

D 9868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 9868

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1043 S. Howard St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Stevenson.(C)

(Residence in Baltimore: No. 1043 S. Howard St. St.: yrs.. 2 mos. 27 ds.)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, August 11th. 1917., / (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edward Stevenson.(C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Phoebe Jones.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimpre, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Phoebe Jones.(C) mother.
(Informant)
(Address) 1043 S. Howard St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia.
unknown.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Nov. 7th., 191.7. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn ct	Nov. 8th. 1917
20-UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Mount St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9869

CERTIFICATE OF DEATH.

79 D 9869

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Margaret Horn

(Residence in Baltimore: No. 40 E. Twenty-fifth St.)

St.: 48 yrs., 5 mos. 15 ds.)

Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, June 21st (Month) (Day) 1869 (Year)

7-AGE, 48 yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House 037
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Arnold

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Louisa Shaeffer

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melancton Horn

(Address) 40 E 25th St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Nov 6 1917, that I saw her alive on Nov 6 1917, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

..... (Duration) ..... yrs. ..... mos. 40 ds.

(Signed) B. W Horn M.D. M. D.

Nov 6, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. ..... mos. 10 ds.

Where was disease contracted, if not at place of death? At Residence

Former or usual residence 40 E. 25th St. [illegible]

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Nov. 7, 191..

20-UNDERTAKER [illegible] Cook

ADDRESS 502 E Nath Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9870

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Spencer

(Residence in Baltimore: No. 2139 Harford Av ST.:) (56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Don't know, 184? (Month) (Day) (Year)

7-AGE, about 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Harford Co.

PARENTS.

10-NAME OF FATHER, Isaac Atkinson

11-BIRTHPLACE OF FATHER (State or Country), Harford Co.

12-MAIDEN NAME OF MOTHER Mary Jane Lewis.

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Atkinson

(Address) 1301 Chestnut Ave - Blvd

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 1917, to Nov. 6 1917, that I saw h me alive on Nov. 6 1917, and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

over

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward H. Jones M. D.

Nov. 7, 191... (Address) Manchester

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? 2139 Harford Rd

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Pk	Nov. 9, 1917
20-UNDERTAKER Wm Cook	ADDRESS 512 E North

important. See instructions on back of certificate.

properly classified. Exact statement of OCCUPATION is very

...ing should state

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9871

28 D 9871

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Josephine Holly

(Residence in Baltimore: No. St. Elizabeth's Home St.; 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	negress	

6-DATE OF BIRTH, couldn't obtain ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
9 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), St. Mary's Co. Md.

PARENTS.

10-NAME OF FATHER, Absolom Langley

11-BIRTHPLACE OF FATHER (State or Country), Judicial Place St. Mary's Co.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to November 4 1917, that I saw h er alive on November 4 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Epilepsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Dyer M. D.

Nov. 6, 191 7. (Address) 1937 E. Monument St.

*State the DISEASES CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

important. See instructions on back of certificate.

5276

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9872

CERTIFICATE OF DEATH.

92 D 9872

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1134 W. Lexington St.; 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter M. Wilson

(Residence in Baltimore: No. 1134 W. Lexington St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 24 (Day), 1856 (Year)

7-AGE, 61 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoeworker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, Richmond Wilson

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Emma Harris

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma J. Wilson

(Address) 113 W. Lexington

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1917, to Nov 7 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

11/7, 191.7 (Address) 117 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Nov 9, 191.7

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

State occupation in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9873

CERTIFICATE OF DEATH.

151 D 9873

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Anchor ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franklin P. Phillips

(Residence in Baltimore: No. 1321 Anchor St.; .....yrs., ...mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. (Month) 23 (Day), 1917 (Year)

7-AGE, ...yrs. .....mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edgar Phillips

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Teresa Walter

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. White

(Address) 1149 Covington St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1917, to Nov 7 1917, that I saw him alive on Nov 7 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

..... (Duration) .....yrs. .....mos. 15 ds.

CONTRIBUTORY (Secondary) Intussusception

..... (Duration) .....yrs. .....mos. 2 ds.

(Signed) R. L. Cameron M. D.

Nov 7, 1917. (Address) 1644 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov 8, 1917.

20-UNDERTAKER M. A. Elgin ADDRESS 1422 Light St.

Should state whether single, married, widowed or divorced. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 E. 22nd ST.; 9 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Whelle

(Residence in Baltimore: No. 515 E 22nd St.; 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, May (Month) 18th (Day) 1828 (Year)

7-AGE, 89 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Yakel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas V. Whelle

(Address) 515 E 22nd St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1914, to Nov. 6 1917, that I saw h[er] alive on Nov. 6 1917, and that death occurred, on the date stated above, at 1.40 m.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 3 yrs. ....mos. ....ds.

(Signed) C. M. Lee M. D.

Nov. 6, 1917. (Address) 1239 Williams St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Nov. 9, 1917.
20-UNDERTAKER M. J. Telgmann	ADDRESS 1422 Light

important. See instructions on back of certificate.

...rly classified. Exact statement of OCCUPATION is very ...ssary, so that it may be properly ...ns in plain terms, so that ...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9875

CERTIFICATE OF DEATH.

64 D 9875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 Orleans ST.; 6th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jacob Woollert

(Residence in Baltimore: No. 2038 Orleans St.; 48 yrs., 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June 25, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stockkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Woollert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Woollert

(Address) 2038 Orleans St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Nov 5 1917, that I saw h[illegible] alive on Nov 4 1917, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Edward J. Cook M. D.

11-5, 191.7 (Address) 1113 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Paul Cem.	Nov 8, 191.7
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

It may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9876

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 w. Lexington St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Aged Mens Home

2-FULL NAME William Van Marter

(Residence in Baltimore: No. 1400 w. Lexington st St.; 30 yrs., 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	widower

6-DATE OF BIRTH, Sept 27, 1842 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 1 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Wm Van Marter

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Ellsworth Jones

(Address) 2429 Arunah Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191 7, to Nov 7 191 7, that I saw h alive on Nov 6 191 7, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. .... mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ....yrs. .... mos. 1 ds.

(Signed) ..... M. D.

Nov 8, 191.. (Address) 1330 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. ds. In the State 72 yrs. mos. ds.

Where was disease contracted, if not at place of death? Aged Mens Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cy — DATE OF BURIAL, Nov 10, 191 7

20-UNDERTAKER Jos Jacobs & Son — ADDRESS 2178 W. Pratt

IMPORTANT.—Physicians should state PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 9877

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Hotel Allen 308 N. High St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George W. Collins

(Residence in Baltimore: No. 114 S. Collington Ave St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	married

6-DATE OF BIRTH, June 13, 1869
(Month) (Day) (Year)

7-AGE, 48 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Police Officer
(b) General nature of industry, business, or establishment in which employed (or employer): 061

125

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo. W. Collins

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ann Rebecca Vickers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Wright

(Address)

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6 found dead, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounds by pistol shot and ...
brain.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Sudden

(Duration) ...yrs. ...mos. ...ds.

(Signed) W. A. Riley M. D.
(Coroner.)

Nov. 7, 1917 (Address) 1059 Druid ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov 8, 1917
20-UNDERTAKER	ADDRESS
P. E. Hughes	17 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 9878

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Harford Avenue ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Murphy

(Residence in Baltimore: No. 729 Harford Avnue. St.: 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH. Dec. 5 (Month) (Day), 1845 (Year)

7-AGE. 71 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 030
(b) General nature of industry, business, or establishment in which employed (or employer): Statincary Engineer

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Edward Murphy

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Bridget Bradley

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hogh McLaughlin

(Address) 729 Harford Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1917, to Nov 6, 1917, that I saw him alive on Nov 5 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows: Chronic appendicitis + Apoplexy

(Duration) yrs. 10 mos. 0 ds.

CONTRIBUTORY (Secondary) Pressure on brain by blood clot

(Duration) yrs. mos. 3 ds.

(Signed) Wm. M. Hanlon M. D.

Nov 6 1917 (Address) 7 W. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Nov 9, 1917

20-UNDERTAKER Chas. J. Evans & Son ADDRESS 11 E. Fond Royal Place

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9879 — 120 — D 9879

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Stein

(Residence in Baltimore: No. 204 Lloyd St.; ..... yrs., Unknown mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) ....., 1863 (Year)

7-AGE, 54 yrs. 7 mos. — ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 30 1917, to Nov 8, 1917, that I saw him alive on Nov 8, 1917, and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Myocarditis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Decompensation

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Isaac Steinglass M. D.

Nov 8, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 204 Lloyd St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	11 9, 1917

20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 48

17

Isaac Lewis

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 D 9880

628 CERTIFICATE OF DEATH.

79 D 9880

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 628 Bragg ST.: 17 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Lewis

(Residence in Baltimore: No. 628 Bragg St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... September ....., 1844
(Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ed Dept City

75

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs

(Address) 628 Bragg St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. ..... 6 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)

.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

.....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY..... Senility
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed)..... M. D.
(Coroner)

Nov. 7, 1917 (Address) 98 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State....yrs.....mos.....ds. Many

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov. 8, 1917

20-UNDERTAKER Chas. G. Bailey

ADDRESS 1142 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9881

CERTIFICATE OF DEATH.

64 D 9881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Madison St.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Fisher

(Residence in Baltimore: No. 2812 E. Madison St.; 65 yrs.. mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept. 1, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Will

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Sophia Kraemer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E Fisher

(Address) 2812 E Madison St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 191 7, to Nov 6 191 7, that I saw her alive on Nov 6 191 7, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) Wm E Mayer M. D.

Nov 8, 191 7 (Address) 2000 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov. 9, 1917.

20-UNDERTAKER Armstrong Denny Co

ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9882

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 McCulloh ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucrelia Ann Tall

(Residence in Baltimore: No. 1417 McCulloh St.; 70 yrs. 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, January 3, 1847. (Month) (Day) (Year)

7-AGE, 70 yrs. 9 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James H. Myers

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sarah Merriken

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ida M. Carruth

(Address) 1417 McCulloh St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Nov 7th 1917, that I saw h[er] alive on November 7th 1917, and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows,

Carcinoma right breast & right Lung infiltrated

Cervical Glands

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) H. J. Barnes M. D.

Nov 7th, 1917, (Address) 1417 McCulloh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Nov 9, 1917.

20-UNDERTAKER Stewart & Mowen Co — ADDRESS 1081 W. Mt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9883

CERTIFICATE OF DEATH.

152 D 9883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 So. Gilmor ST.; 19 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin Elmer Lawson

(Residence in Baltimore: No. 705 S Gilmor St.; ..... yrs., ... mos. 7 ds.)

CAUSE OF DEATH. Please state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	W.	Single

6-DATE OF BIRTH. Nov 6, 1911
(Month) (Day) (Year)

7-AGE. ..... yrs. 2 mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 080
(b) General nature of industry, business, or establishment in which employed (or employer) 080

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, C. Elmer Lawson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Epp

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. C. Lawson

(Address) 705 So. Gilmor St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 8 1917, that I saw h[illegible] alive on 11-8 1917, and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Acute
Contributory
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel H. Mudd M. D.

11-8, 191... (Address) 1520 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Nov 9, 191..

20-UNDERTAKER Joseph B Cook ADDRESS 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

D 9884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9884

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1751 E Pratt ST.; 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara, Thome

(Residence in Baltimore: No. 1751 E. Pratt St.; 61 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, September (Month) 15 (Day), 1856 (Year)

7-AGE, 61 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 700

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Peter Reist

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Johanna Seimone

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R. Thome

(Address) 1751 E. Pratt

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Nov 6 1917, that I saw her alive on Nov 6 1917, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) [illegible] M. D.

Nov 7, 191.7 (Address) 41 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Nov 9, 191.7
20-UNDERTAKER	ADDRESS
Wendell Diffendal Son	378 Conn

700

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9885

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lt Josh Hospital St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas M Carter

(Residence in Baltimore: No. 2450 Brecklonna St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	Col	Married

6-DATE OF BIRTH, June (Month) 14 (Day), 1889 (Year)

7-AGE, 28 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

243

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Edward Carter

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Fannie Carter

(Address) 2450 Baselmans St.

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain words, so that it may be properly classified. Each item is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Traumatism, accidental
(b) Fell down stairs
(c)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

(Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos...1..ds. In the State.....yrs...3...mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence....West Virginia.

19-PLACE OF BURIAL, OR REMOVAL, Lestermanor King Wm Co. | DATE OF BURIAL, Nov. 8, 1917

20-UNDERTAKER Liston T. Fusselbaugh | ADDRESS 2620 E Hall St

Mrs Fannie Carter Passenger.

Pier 19 Light St.

15-

Filed....., 191.....
Registrar.

19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D 9886 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9886

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Edmondson St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Arnie Hausser

(Residence in Baltimore: No. 1622 Edmondson Ave St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 30, 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. 2 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 080

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Hausenhausser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Julia Lemmer

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie M. Eisse

(Address) 1622 Edmondson Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 7 1917, that I saw h.. alive on Nov 6 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilation

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Edward Krug M. D.

Nov 7, 191... (Address) 1622 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westerly | DATE OF BURIAL, Nov. 9, 1917

20-UNDERTAKER George L. Schmidt & Bro | ADDRESS 101 Fulton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9887

D 9887

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Royal Apartments, ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raleigh Colston Smith.

(Residence in Baltimore: No. Mount Royal Apartments. St.; 7 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married.

6-DATE OF BIRTH, ... February 2nd, 1867.
(Month) (Day) (Year)

7-AGE, 50 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Newspaper
(b) General nature of industry, business, or establishment in which employed (or employer): Business. 04

9-BIRTHPLACE, (State or Country), Clarke Co Va.

PARENTS.

10-NAME OF FATHER, John Philip Smith.

11-BIRTHPLACE OF FATHER (State or Country), Clarke Co Va.

12-MAIDEN NAME OF MOTHER Sally Bland Newton.

13-BIRTHPLACE OF MOTHER (State or Country) Westmorland Co Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Raleigh Colston Smith.

(Address) Mount Royal Apartments.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 7th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 191.., to Nov 4 191..,
that I saw him alive on Nov 7 191..,
and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis
(b) Cardiac Dilatation
(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia
(Duration) yrs. mos. 10 ds.

(Signed) Christian Fenger M. D.

Nov 8, 191.., (Address) 1327 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Winchester Va. DATE OF BURIAL, Nov. 10..., 1917.

20-UNDERTAKER Henry H. Jenkins & Sons Co ADDRESS 716 Eutaw & Richard Sts.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 9888

REGISTERED NO. C.....

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Mc Elgunn

(Residence in Baltimore: No. Little Sisters of the Poor St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Wid

6-DATE OF BIRTH. Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE. 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Mc Elgunn

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Anne Boyle

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Sister Benedict.....

(Address) Little Sisters of the Poor

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7th, 191?
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 ,
that I saw h[illegible] alive on Nov 3 191?,
and that death occurred, on the date stated above, at 1.? m.
The CAUSE OF DEATH* was as follows:

.....Interstitial nephritis.....
.....
.....
.....Unknown..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed).....T Mulrooney.....M. D.
Nov 8....., 191.. (Address) 1133 Valley.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. mos. ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL. St. Peters Cemetery — DATE OF BURIAL. Nov 10, 191?

20-UNDERTAKER H. C. Woodyard — ADDRESS 214 Gramm Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 9889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9889

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C .....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Clifford

(Residence in Baltimore: No. Little Sisters of the Poor - St.; Lifts mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Edward Clifford

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Ellen McKenna

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict .....

(Address) Little Sisters of the Poor .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 8th .....
(Month) (Day)
....., 191?
(Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... to record ..... 191 ....., that I saw h.. alive on Nov 3 191?, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

..... Unknown ..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 8, 191?. (Address) 1132 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Little Sisters of the Poor.

19-PLACE OF BURIAL OR REMOVAL. St. Patricks Cemetery

DATE OF BURIAL. Nov. ....., 191?

20-UNDERTAKER J. C. Rudolf

ADDRESS 1918 Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9890

CERTIFICATE OF DEATH.

1917 D 9890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home St.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Monroe

(Residence in Baltimore: No. 1402 W. Lexington St.; 80 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) Nov. (Day) 5 (Year) 1832

7-AGE. 85 yrs. ..... mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (Mrs.) Jones

(Address) Matron

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to Nov 7 1917, that I saw h alive on Nov 7 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis,

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(Duration) 7 days yrs. ..... mos. 1 ds.

(Signed) Thos. W. Hall M. D.

Nov. 8, 1917. (Address) 137 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. ..... mos. ..... ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? at the Home

Former or usual residence at the Home

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov. 9, 1917.

20-UNDERTAKER Geo. J. Smith

ADDRESS 1000 N. Eutaw St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9891

CERTIFICATE OF DEATH.

40

D 9891

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 E. Eager ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Meyers

(Residence in Baltimore: No. 1636 E Eager St.; 57 yrs., \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
57 yrs. \ mos. \ ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, William Beck

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary J. Beck

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Henry Meyers

(Address) 1636 E Eager St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 6, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1917, to Nov 6 1917, that I saw h- W alive on Nov 6 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

a. Carcinoma of Liver

Clinical (Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Jarvis M. D.

Nov 7 1917 (Address) 1367 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Nov 7, 1917

20-UNDERTAKER Henry Horch Son

ADDRESS 1301 E Eager St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9892

CERTIFICATE OF DEATH.

Corrected by Dr Thomas Entered 1364 D 9892

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Trinity Street 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Pica.

(Residence in Baltimore: No. 913 Trinity St. St.; 15 yrs., 7 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, April (Month) 29 (Day), 1894 (Year)

7-AGE. 23 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Sabastiano Scandora

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Francis Salandi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonio Pica

(Address) 913 Trinity

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 6 1917, that I saw h[illegible] alive on Nov 6 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Brain hemorrhage (Childbirth)

Cardiac syncope

Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. D. Grandis M. D.

11-7, 1917. (Address) 1024 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Ca

DATE OF BURIAL, Nov. 9, 1917.

20-UNDERTAKER Tilly & Zeile

ADDRESS 403 S. Wolfe St.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9893

CERTIFICATE OF DEATH.

120 D 9893

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2458 W Baltimore ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Mc Guire

(Residence in Baltimore: No. 2458 W Baltimore St. 50 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct 2, (Month) (Day) 1866 (Year)

7-AGE, 50 yrs. 1 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, — Hunkal

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER — Hopkins

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Daughter in law Informant Mrs Ellen Mc Guire

(Address) 2458 W Baltimore St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1917, to Nov 6th 1917, that I saw h Er alive on Nov 6th 1917, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Myocarditis, & Cardiac Asthenia

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. F. Kuhl M. D.

Nov 7, 191.. (Address) 1 S Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Nov 9, 1917

20-UNDERTAKER Rabbit & Turner

ADDRESS 1474 W Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 ✓ D 9894

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 So. Gaeen ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph W. Gray

(Residence in Baltimore: No. 715 So. Green St.: 30 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, unknown (Month), (Day), 1862 (Year)

7-AGE: 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, Joseph Gray

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Carter

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward H. Gray

(Address) 715 Hanover St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 7 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 191 , to Nov 7 191 , that I saw h alive on Nov 6 191 , and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

(a) Apoplexy

(b)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(Duration) yrs. mos. ds.

(Signed) Edward Gorter M. D.

Nov 8, 191 7 (Address) 1612 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Governors Run DATE OF BURIAL, Nov 16, 191 7

20-UNDERTAKER J. C. H. Leadum ADDRESS 142 W. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9895

CERTIFICATE OF DEATH.

11 D 9895

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Ridgewood Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Edward Mittinger

(Residence in Baltimore: No. 2010 Ridgewood ave St.: ....yrs., mos. 5 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.)
Male	White	

6-DATE OF BIRTH, ... Nov. 2, ..., 1917...
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Mittinger

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Laurine M. Daniels

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amos E. Daniels

(Address) 2010 Ridgewood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. ..... 7 ....., 1917...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1917, to Nov. 7, 1917, that I saw him alive on Nov. 7, 1917, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

.....Convulsions.....
.....(Uremia)
..... (Duration)....yrs....mos....ds. 7 days

CONTRIBUTORY (Secondary)
..... (Duration)....yrs....mos....ds.

(Signed) ...Maurice E. Shamer... M. D.

Nov. 8, 191.7. (Address) 3.300 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov. 9, 191.7

20-UNDERTAKER Joseph J. Cook ADDRESS 1003 W. Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D 9896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 9896

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Wilson ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Williams

(Residence in Baltimore: No. 518 Wilson St.; 0 yrs., 0 mos. 0 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. All information must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 8 (Day), 1917 (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 8 hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

000 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles E. Williams

11-BIRTHPLACE OF FATHER (State or Country), Richmond, Va.

12-MAIDEN NAME OF MOTHER Mary Green

13-BIRTHPLACE OF MOTHER (State or Country), Essex Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Williams

(Address) 518 Wilson St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 8, 1917, to November 8, 1917, that I saw her alive on November 8, 1917, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Douglass M. D.

Nov. 8, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cmty

DATE OF BURIAL, Nov 9, 1917

20-UNDERTAKER Jno H Holland

ADDRESS 1611 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9897

D 9897

CERTIFICATE OF DEATH.

X 64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Hosp. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Lewis Lutz

(Residence in Baltimore: No. Middletown Md. St.; 71 yrs., 11 mos. 10 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, January 21, 1838
(Month) (Day) (Year)

7-AGE, 79 yrs. 11 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 068

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ludwig Lutz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. C. Lutz

(Address) Middletown Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-5 1917, to 11-8 1917, that I saw h[illegible] alive on 11-8 1917, and that death occurred, on the date stated above, at 3:40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11-8, 191.. (Address) Middletown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 68 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at residence

Former or usual residence Middletown Md.

19-PLACE OF BURIAL OR REMOVAL Middletown Md DATE OF BURIAL, 11/8, 191.7

20-UNDERTAKER E & S Earle ADDRESS 115 E. Main St

D 9898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 329 S Bond St ST. V WARD)

2-FULL NAME Carl Weyzynoski

(Residence in Baltimore: No. 329 S Bond St

REGISTERED No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 1 mos. 20 ds.)

D 9898

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 20 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Weyzynoski

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mary Pinsko

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Weyzynoski

(Address) 329 S. Bond St.

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

6 hours (Duration) ....yrs. ....mos. ....ds.

(Signed) Chemung Conn Coroner. M. D.

Nov 8, 1917 (Address) 616 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov 9, 1917

20-UNDERTAKER	ADDRESS
Wm Trallinger	616 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

53 D 9899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Madison ave ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon M. Stein

(Residence in Baltimore: No. 2018 Madison ave St.; Unk yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. ... should be stated EXACTLY. PHYSICIANS should state ... be carefully supplied. AGE should ...

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 51 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... J Lewis

(Address) ..... 1411 E Balt

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8th ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1917, to Nov 7 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

..... Lymphatic Leukaemia .....

..... (Duration) 8 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Cardiac Failure ..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... C Matthew Quelch ..... M. D.

Nov 8, 1917. (Address) 817 Park ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Hebrew Rest

DATE OF BURIAL, Nov 9 ....., 1917

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt

Spec.—5-19-13—M. & T.—500 Bks.

D 9900

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D 9900

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 N. Madeira ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sybil T. Schuensen

(Residence in Baltimore: No. 1507 N. Madeira St St.: 14 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. ACE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	married

6-DATE OF BIRTH, January (Month) 25 (Day), 1886 (Year)

7-AGE, 31 yrs. 9 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles E Willett

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Susan R. Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael T Schuensen

(Address) 1507 N. Madeira St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1917, to Nov 7th 1917, that I saw h- alive on Nov 7th 1917, and that death occurred, on the date stated above, at 9-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Arthritis (Rheumatism)

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. 4 ds.

(Signed) Albert E Willett M. D.

Nov. 8, 1917. (Address) 1419 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov 10, 1917.
20-UNDERTAKER	ADDRESS
Wm B. Spence	1325 N. Caroline St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9901

CERTIFICATE OF DEATH.

28 D 9901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. Duncan ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Constantine R. Freund

(Residence in Baltimore: No. 116 S. Duncan St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... Jan (Month) 4 (Day), 1883 (Year)

7-AGE, 34 yrs. 10 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brick layer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Andrew Freund

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Christina Mettinger

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Adams

(Address) 118 S. Duncan

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1917, to Nov 7 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Edward E. Carl M. D.

Nov 8, 1917 (Address) 413 N. Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Nov. 10, 1917

20-UNDERTAKER Jos. J. Kerr | ADDRESS 156 N. Luzerne Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 9902

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 Chester St. ; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Adams

(Residence in Baltimore: No. 945 Chester St. St.; 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Donnell

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Catharine Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Miller

(Address) 2304 E. Jefferson St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Nov 7 1917, that I saw h er alive on Nov 6 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 030

(Duration) yrs. mos. ds.

(Signed) Martin Cordell Smith M. D.

Nov 7, 1917 (Address) 112 E Eday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov 9 1917

20-UNDERTAKER Christian Miller — ADDRESS 2304 E Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9303

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital, 9 WARD)

CERTIFICATE OF DEATH.

X 159 D 9303

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C Hermann

(Residence in Baltimore: No. Raspberry and St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Feb (Month) 20 (Day), 1863 (Year)

7-AGE, 54 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)..... 013

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Christian Hermann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Helen Krapf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Hermann

(Address) 146 Kenwood Ave Raspberry

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 7 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by firearms

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... (Coroner) .....M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 10, 1917

20-UNDERTAKER H. Sander & Sons — ADDRESS 710 W Lex St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9901

CERTIFICATE OF DEATH.

38 D 9901

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sasah Broadway

(Residence in Baltimore: No. 769 Vine St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) Autumn (Day) ....., 1904 (Year)

7-AGE, ..13..yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Broadway

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Broadway Mother

(Address) 769 Vine St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Nov (Day) 6, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from October 29 1917, to Nov 6 1917, that I saw h alive on Nov 6 1917, and that death occurred, on the date stated above, at 3. m.

The CAUSE OF DEATH* was as follows:

..... Surgical Shock.

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Salpingitis (operation)

..... (Duration) ....yrs. 1 mos. ....ds.

(Signed) ..... M. D.

11/8, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. 2 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 769 Vine St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct — DATE OF BURIAL, Nov 11, 1917

20-UNDERTAKER L. E. Browne & Son — ADDRESS 1 & S W Monty

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 9905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9905

CERTIFICATE OF DEATH

1 PLACE OF DEATH 27 N Carey St.

CITY OF BALTIMORE: (No. Robert Garrett Hospital 19 Ward)

REGISTERED NO. C 151

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Anders

(Residence in Baltimore: No. 318 South Bruce St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DO NOT WRITE IN THIS SPACE

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May 7 (Month) (Day), 1917 (Year)

7-AGE: yrs. 7 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Richmond Va.

PARENTS

10-NAME OF FATHER: Richard Andres

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Hedwich Mozer

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Andres

(Address) 318 South Bruce St.

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 8 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191 ..., to, Nov. 8 1917, that I saw h[im] alive on November 8 1917, and that death occurred, on the date stated above, at 11 20 m.

The CAUSE OF DEATH* was as follows:

Marasmus

Could not assimilate food since birth (Duration) yrs mos ds

Contributory (SECONDARY): Improper feeding (Duration) yrs 5 mos — ds

(Signed) John C Krech M. D.

November 8 1917 [Address] 27 N. Carey St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 10 ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Nov 9th 1917

20-UNDERTAKER: Knell & Son

ADDRESS: 1729 W Pratt st

D 9906

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 D 9906

1 PLACE OF DEATH

REGISTERED No. C ....

CITY OF BALTIMORE (No. Home for Incurables Guilford Ave & 21st St. Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen C. Pope

(Residence in Baltimore: No. Home for Incurables St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH ? (Month) ? (Day) 1845 (Year)

7 AGE 72 yrs. ? mos. ? ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) Unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Home for Incurables

(Address) Guilford Ave & 21st St.

15

Filed NOV 10 1917, 191 ....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 8 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1917, to Nov 8th 191 7, that I saw h[illegible] alive on Nov 7th 191 7, and that death occurred, on the date stated above, at 5 P, m.
The CAUSE OF DEATH* was as follows:

Ventricular heart failure

(Duration) 8 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Gabriel M. D.

Nov 9, 191 7 (Address) 2413 E Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 8 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 10, 191 7

20 UNDERTAKER J. E. Hughes — ADDRESS 19 S Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9907

CERTIFICATE OF DEATH.

101 D 9907

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Penna Alley ST.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Webster Price

(Residence in Baltimore: No. 624 Penn Alley St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ... (Month) — (Day) 1867. (Year)

7-AGE,	If LESS than 1 day,
50 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter — Oyster House
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

24 3

9-BIRTHPLACE, (State or Country), St Marys Co - Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Purnell

(Address) 624 Penn Alley

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov 7th 1917, that I saw h... alive on Nov 5th 1917, and that death occurred, on the date stated above, at 11.2 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Broncho Pneumonia (Duration) — yrs. — mos. 2d ds.

CONTRIBUTORY (Secondary) Abscess of Liver

Oesophagus (Duration) — yrs. 2 mos. — ds.

(Signed) Edward E. Mackenzie M. D.

Nov 8th, 191.. (Address) 133 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov 9, 191..
20-UNDERTAKER Charles B. Jones	ADDRESS 1330 Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9908

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 9908

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Oak St. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr James A Joyce (Joyce)

(Residence in Baltimore: No. 2017 Oak St. St.; 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

243

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, (a) Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Unknown (Month) x (Day), 1868 (Year)

7-AGE, 49 yrs. x mos. x ds. If LESS than 1 day, x hrs. or x min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): x 041

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Joyce

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) His wife Mrs Edwina Joyce

(Address) 2017 Oak St

15-

Filed Nov 7, 1917 S6243 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 1917, to Nov 6 1917, that I saw him alive on Nov 6 1917, and that death occurred, on the date stated above, at 12 45 p.m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia (Bilateral)

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ? yrs. ? mos. ? ds.

(Signed) Dr. Geo. L. Hall M. D.

Nov 7, 1917. (Address) 1628 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. ds. In the State 49 yrs. x mos. x ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Nov. 9, 1917.

20-UNDERTAKER Sam'l H. Chase & Son ADDRESS 1400 Mosher

17.
48
29 D 9909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9909

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1108 N. Carrie ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Means

(Residence in Baltimore: No. 1108 N. Carrie St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1869 (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Woman 070
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private 933

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Hall

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Son

(Address) 1108 N Carrie St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Mitchell M. D.
(Coroner)

....., 191.. (Address) 1108 Carrie St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, June 10 1917

20-UNDERTAKER Charles B. Jones

ADDRESS 935 Pine St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9910

CERTIFICATE OF DEATH.

91 D 9910

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 S Sterling ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hutchins

(Residence in Baltimore: No. 731 Sterling St; 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE, negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH, Nov. 6, 1868
(Month) (Day) (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~no pair~~ 041
(b) General nature of industry, business, or establishment in which employed (or employer) washing & ironing

8244

9-BIRTHPLACE, (State or Country), Balto. city

PARENTS.

10-NAME OF FATHER, Geo. Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary J. Hubbard

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Simms, daughter

(Address) 810 S Sterling St.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 1917, to Nov. 6 1917, that I saw her alive on Nov. 5 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

Nov. 7 1917. (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary

DATE OF BURIAL, Nov. 9, 1917.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 504 East St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 0911 — D 0911

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1815 N. Wolfe St.; 8 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta De Fonter

(Residence in Baltimore: No. 1815 N. Wolfe St.; 32 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec 12th, 1885
(Month) (Day) (Year)

7-AGE, 64 yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Gaetano Lamenza

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Tomasea Palomba

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Michael Dulnca

(Address) 1815 N. Wolfe St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 8th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Nov 8 1917, that I saw her alive on Nov 7 1917, and that death occurred, on the date stated above, at 1.05 Am.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nefritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration).....yrs. 2 mos.....ds.

(Signed) Jacob Fisher M. D.

Nov 5, 1917. (Address) 1523 N. Wash St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral Cem	Nov 13th, 1917
20-UNDERTAKER	ADDRESS
Chas J. Evans & Son	118 W Mt Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9912

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 614 S. Regester ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Auguste H. Rossmark

(Residence in Baltimore: No. 614 S. Regester St. St.; 24 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH October 1st, 1861.
(Month) (Day) (Year)

7-AGE, 56 yrs. 1 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housework

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Adolph Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Rossmark

(Address) 614 S. Regester St.

15-

Filed....., 191.... Robt Knecht
Registrar.

5

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 8th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 6th, 1917 to November 8th, 1917 that I saw her alive on November 8th, 1917, and that death occurred, on the date stated above, at 6.55 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
2nd attack.
3
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Hemiplegia
(Duration) 1 yrs. 1 mos. 7 ds.

(Signed) Charles H. A. Meyer M. D.

Nov. 8th, 1917. (Address) 103 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St. Evangelical Cemetery	Nov. 12, 1917.
20-UNDERTAKER Walter MacFarlew	ADDRESS 2732 Huntington Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9913

CERTIFICATE OF DEATH.

39 ✓ D 9913

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2351 Frederick Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew A Hoffmann

(Residence in Baltimore: No. 2351 Frederick Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 16, 1876
(Month) (Day) (Year)

7-AGE, 40 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 004

800

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andrew Hoffmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie L Hoffmann

(Address) 2351 Fredk: Ave:

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov: 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 24 1917, to Nov. 7th 1917, that I saw h.m alive on Nov 5th 1917, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows: Carcinomatosis of Stomach

Exhaustion

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

....., 191.. (Address) 652 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, Nov: 10, 1917

20-UNDERTAKER Chas W. Dill

ADDRESS 3109 Fredk: Ave:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102 D 9913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 N. Luzerne St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Smith

(Residence in Baltimore: No. 1216 N. Luzerne St.; Litter yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan. 3, 1891 (Month) (Day) (Year)

7-AGE, 26 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Examiner
(b) General nature of industry, business, or establishment in which employed (or employer) Shirts

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Orlando L. Smith, Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary A. Gross

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Orlando L. Smith

(Address) 1216 N. Luzerne

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917 to Nov 8 1917, that I saw h[illegible] alive on Nov 8 1917, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) 4 hrs. 1 mo. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. 1 mo. ds.

(Signed) William F. Faith M. D.

Nov 9, 1917 (Address) 1427 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oaklawn

DATE OF BURIAL, Nov. 12, 1917.

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1738 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9915

CERTIFICATE OF DEATH.

120 D 9915

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Smallwood ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Dunkerly

(Residence in Baltimore: No. 425 S. Smallwood St. 52 yrs., 1 mos. 7 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (*Write* the word.) Married

6-DATE OF BIRTH, 7 (Month) 1 (Day) 1865 (Year)

7-AGE, 52 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Richard E. Dunkerly

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Dunkerly

(Address) 425 S. Smallwood St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1916, to Nov 8 1917, that I saw him alive on Nov 7 1917, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis Valvular heart Trouble

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry Goldberg M. D.

11-8, 1917. (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem (DATE OF BURIAL, Nov. 12, 1917)

20-UNDERTAKER Jos R Cook (ADDRESS 1003 W Balto St)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9916

CERTIFICATE OF DEATH.

92

D 9916

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2913 ST.: Cedar Ave WARD 18) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Redman.

(Residence in Baltimore: No. 2913 St.: Cedar Ave 72 yrs., mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widow

6-DATE OF BIRTH. October 15, 1845.
(Month) (Day) (Year)

7-AGE. 72 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Redman

(Address) 2913 Cedar Ave

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov 8 1917, that I saw h[illegible] alive on Nov 8 1917, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

[redacted]
Acute Interstitual Nephritis
Uremia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(Duration) yrs. mos. 5 ds.

(Signed) C. F. Brown M. D.

Nov 8, 1917. (Address) 801 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bapto Cemetery	Nov 10, 1917
20-UNDERTAKER	ADDRESS
Dennoth & Son	20 Hartland 7917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9917

146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hosp. REGISTERED No. C.....

CITY OF BALTIMORE: (No. Caroline & Oliver ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Stefan

(Residence in Baltimore: No. 815 S. Curley St.; 32 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 2, 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, George Steffan

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Anna Julius

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Stefan

(Address) 815 S. Curley St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191..., to Nov 7 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ....yrs. ....mos. 2 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

(Signed) J. Finney Hunter M. D.

....., 191... (Address) 2 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~ yrs. ~ mos. 2 1 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence 815 S. Curley St.

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov. 10, 1917.

20-UNDERTAKER Stephen J. Kalkowski — ADDRESS 1019 S. Kenwood Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

17
6 7 D 9918 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9918
5 0

CERTIFICATE OF DEATH.

92

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 714 N. O'Brien ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Hammond

(Residence in Baltimore: No. 714 N. Brien St.; Yrs., 7 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Married

6-DATE OF BIRTH, ... September, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

243

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles Hammond

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lelia Gordon

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wife

(Address) 714 N. Brien

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration).....yrs.....mos.....7.....ds.

CONTRIBUTORY (Secondary) Gen'l Debility

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner.)

....., 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 7 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Lily Forest Co. Md.	November, 1917.
20-UNDERTAKER	ADDRESS
Felix B. Pye	922 Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9919 — PLACE OF DEATH — 64 ✓ — D 9919 — REGISTERED No. C

CITY OF BALTIMORE (No. 1313 N Whitecoat ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Wilson

(Residence in Baltimore: No. 1313 N Whitecoat St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fem

4-COLOR OR RACE: Col

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: May 6, 1882 (Month) (Day) (Year)

7-AGE: 35 yrs. 10 mos. 2 ds. — If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Wallace Turner

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maycell Mosby

(Address) 1313 N Whitecoat St

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 8 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1917, to Nov. 7 1917, that I saw her alive on Nov 7 1917, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 11 ds

Contributory (SECONDARY) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hamilton Eugene M. D.

Nov. 8, 1917. (Address) 1006 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Nov 11 1917

20-UNDERTAKER: Felix E. Rice — ADDRESS: 1026 Mulberry

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain statement of OCCUPATION is very important. See instructions

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

D 9920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9920

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 N. Glover ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Vincent Croghan Sr.

(Residence in Baltimore: No. 533 N. Glover st. St.; 54 yrs., 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH, Aug. (Month) 30 (Day), 1863 (Year)

7-AGE, 54 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: City Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): 061

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Peter Paul Croghan

11-BIRTHPLACE OF FATHER (State or Country), County Roscommon Ireland

12-MAIDEN NAME OF MOTHER Elizabeth A. Connor.

13-BIRTHPLACE OF MOTHER (State or Country), County Roscommon Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cashier A. J. Croghan

(Address) 533 N. Glover St Balto Md.

15-

Filed....., 191.....

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 9 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1916, to Nov. 9 1917, that I saw h[illegible] alive on Nov. 9 1917, and that death occurred, on the date stated above, at 7.35 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Cystitis
Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. 2 mos. 24 ds.

(Signed) Louis Vogt M. D.

Nov. 9, 1917. (Address) 1601 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cem — DATE OF BURIAL, Nov. 12, 1917

20-UNDERTAKER, Chas. H. Evans & Son — ADDRESS, 11 Mont Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9921

CERTIFICATE OF DEATH.

79 ✓ D 9921

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N. Mount ST.: 16th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Louise Graham

(Residence in Baltimore: No. 712 N. Mount St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 86 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Dublin Ireland

PARENTS.

10-NAME OF FATHER, Thomas Ross

11-BIRTHPLACE OF FATHER (State or Country), Dublin

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. R. Graham

(Address) 712 N. Mount St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov- 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct- 31 1917, to Nov-8- 1917, that I saw h- alive on Nov- 7- 1917, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Myocarditis 4 years

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation Sudden

(Duration) ....yrs. ....mos. .....ds.

(Signed) Thomas Jones M. D.

11-9-, 1917. (Address) 1802 Eastern Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov. 10, 1917

20-UNDERTAKER Henry W. Jenkins Sons & ADDRESS Mc. Culloh & Orchard St

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9922

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 9922

CERTIFICATE OF DEATH.

REGISTERED NO. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Bell ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Robert Gregory

(Residence in Baltimore: No. 1410 Bell St.; 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Jan (Month) 22 (Day), 1856 (Year)

7-AGE, 61 yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saw maker
(b) General nature of industry, business, or establishment in which employed (or employer): Saw factory

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John N Gregory

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret McClung

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert E Gregory

(Address) 1410 Bell Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Nov 8 1917, that I saw him alive on Nov 7 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Sublubsation 7 cervical vertebra, fracture fall down stairs (accidental)

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Wm E Stifler M. D.

11/8, 1917. (Address) 1319 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Nov 10 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1432 Light St

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

260

D 9923

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

D 9923

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2242 E.Baltimore St. St.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard M.Bowen.

(Residence in Baltimore: No. 2242 E.Baltimore St.: 33 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married.

6-DATE OF BIRTH: April 10th. 1849. (Month) (Day) , 1 (Year)

7-AGE: 68 yrs. 6 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work: Commission merchant.

(b) General nature of industry, business, or establishment in which employed (or employer): 0445

9-BIRTHPLACE (State or country): Calvert Co,Md.

PARENTS

10-NAME OF FATHER: Octavus Bowen.

11-BIRTHPLACE OF FATHER (State or country): Calvert Co,Md.

12-MAIDEN NAME OF MOTHER: Ann Pardoe.

13-BIRTHPLACE OF MOTHER (State or country): Calvert Co,Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Edith R. Reinhardt. (daughter)

(Address) 2242 E.Baltimore St.

15

Filed ....., 191 .....

REGISTRAR .....

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 8th. 1917. (Month) (Day) , 191 (Year)

17. I HEREBY CERTIFY. That I attended deceased from Nov,3rd. , 1917 . to. Nov.8th 1917 .

that I saw h im alive on Nov,8th. , 1917 ,

and that death occurred. on the date stated above. at 2.30P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ... yrs. ... mos. 5 ds

Contributory (SECONDARY) Exhaustion.

(Duration) yrs. mos. ds.

(Signed) Edith M Reinhardt M. D.

Nov,8th , 1917 (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov. 10 , 1917 .

20-UNDERTAKER: Wm C. Black

ADDRESS: 927 N. Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

D 9921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 9921

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Nauman

(Residence in Baltimore: No. 9 S. Bond St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 22, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm J. Nauman.

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Mary C. Holen

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Nauman

(Address) 9 S. Bond St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1917, to Nov 9 1917, that I saw him alive on nov 8, 1917, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ....yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) ....yrs. ....mos. 18 ds.

(Signed) Geo. Hofer M. D.

11-9, 191.7 (Address) 1437 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	Nov. 10, 191.7
20-UNDERTAKER Albert E. Fuller	ADDRESS 221 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 10 1917 ROBERT E. KRAUTER REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 9925

CERTIFICATE OF DEATH.

92 D 9925

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 N. Carlton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Johnson

(Residence in Baltimore: No. 630 N. Carlton St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be accurately stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 34 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day 140
(b) General nature of industry, business, or establishment in which employed (or employer)..... Detroit

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...John Butler.....

(Address) 1118 W. Lexington St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 7 1917, that I saw h.. alive on Nov 7 1917, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration).....yrs.....mos.....7.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

1189....., 191..7 (Address) 117 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 10, 1917

20-UNDERTAKER Brown & Freeland — ADDRESS 114 St. Paul

WHITE PLAINLY, WITH UNFADING INK.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 9926

CERTIFICATE OF DEATH

80 D 9926

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1729 Bolton St.: 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Deborah Rawlings

(Residence in Baltimore: No. 1729 Bolton St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: August 5th, 1842 (Month) (Day) (Year)

7 AGE: 75 yrs. 3 mos. 4 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Balto. Co., Md.

PARENTS

10 NAME OF FATHER: Wm. Cummings Snyder

11 BIRTHPLACE OF FATHER (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Elizabeth Herr

13 BIRTHPLACE OF MOTHER (State or country): Balto. Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. J. Marsden

(Address) 1729 Bolton St.

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 9th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from for many years the present time, 191 . to 191 .

that I saw her alive on June 29th, 1917.

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

She has had attacks of angina pectoris for several years, which doubtless caused her death

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Arterio-Sclerosis of several years duration -

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edward C. Price M. D.

11-10-, 1917 (Address) 1012 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov. 12, 1917

20 UNDERTAKER: Geo. J. Smith

ADDRESS: 1533 W. Pratt St.

NOV 10 1917 ROBERT E. KRAUSER

D 9927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 9927

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 405 Robert. ST.: 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Harris

(Residence in Baltimore: No. 405 Robert St St.; yrs. 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, July 17, 1895
(Month) (Day) (Year)

7-AGE, 19 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Hurlock Md

PARENTS.

10-NAME OF FATHER, Abraham Harris

11-BIRTHPLACE OF FATHER (State or Country), Dalto Md

12-MAIDEN NAME OF MOTHER Rosie Jones.

13-BIRTHPLACE OF MOTHER (State or Country), Hurlock Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Katherine Harris
(Address) 405 Robert St

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) C. Edw. Schmidt M. D.
(Coroner)
11/8, 191.. (Address) 710 Eight St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lamar Cemetery — DATE OF BURIAL, Nov 10, 1917

20-UNDERTAKER James H. Dennis — ADDRESS 1303 Presstman

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9928

CERTIFICATE OF DEATH.

92

D 9928

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1322 Linden Av ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham W. Stehman

(Residence in Baltimore: No. 1322 Linden Av. St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male White

4-COLOR OR RACE, white

5-~~STATE~~, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 11, 1839 (Month) (Day) (Year)

7-AGE, 1839 Jany 11 78 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 045
(b) General nature of industry, business, or establishment in which employed (or employer) Stove Engineer

9-BIRTHPLACE, (State or Country) Conestoga Township Lancaster Co Pa

PARENTS.

10-NAME OF FATHER, Tobias Stehman

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Pa

12-MAIDEN NAME OF MOTHER Ann Gamber

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Co Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tobias B. Stehman

(Address) 1322 Linden ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Nov 9 1917, that I saw him alive on Nov 9 1917, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Grippe

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(Duration) yrs. mos. 3 ds.

(Signed) Robert G. Fechtig M. D.

Nov. 9, 1917 (Address) 1303 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Marietta Penna

DATE OF BURIAL, Nov 11, 191...

20-UNDERTAKER Graham F. Warren

ADDRESS Broadway ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 10 1917 ROBERT B. KRAUTER BURIAL PERMIT

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9929

64 D 9929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woodlawn (Garrison Ave & Forest Pk)

REGISTERED NO. C

CITY OF BALTIMORE: (No. ~~Woodland~~ Hall Hotel ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME L. Charles Winternitz,

(Residence in Baltimore: No. 1701 Ruxton Avenue, St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	married

6-DATE OF BIRTH, June (Month) 18th (Day), 1843 (Year)

7-AGE, 74 yrs. 4 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer):

770 054

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Maurice Winternitz

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Eva Block

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie Winternitz

(Address) 1701 Ruxton Avenue.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 31st 1917, to Nov. 9th 1917, that I saw him alive on Nov. 9th, 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 2 yrs. — mos. — ds.

(Signed) Edw. N. Brush M. D.

Nov. 10, 1917 (Address) 5 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, 11 11, 1917

20-UNDERTAKER D Sondheim ADDRESS 11 Bond Royal

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9930

CERTIFICATE OF DEATH.

74 D 9930

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 924 N. Wolfe St. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wolff

(Residence in Baltimore: No. 924 N. Wolfe St.)

St.; 63 yrs., 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept 6, 1834
(Month) (Day) (Year)

7-AGE, 83 yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Anton Grebmeier

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Wolff

(Address) 924 N. Wolfe St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1916, to Nov 8 1917, that I saw her alive on Nov 7 1917, and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Myocarditis

(b)

(c) (Duration) 1 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis.

(Duration) 0 yrs. 0 mos. 3 ds.

(Signed) Henry C. Dade M. D.

Nov 9, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Nov 12, 1917.

20-UNDERTAKER F. B. Wehrmeister

ADDRESS 2236 Frederick Ave

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 10 1917 POWELL E. CRAUTER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9931

CERTIFICATE OF DEATH.

1589 D 9931

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2215 Hunter ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winslar Johnson

(Residence in Baltimore: No. 2215 Hunter St

St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 31, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Owens Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Boulden

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Johnson

(Address) 2215 Hunter St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) John F. Mosser M. D.
(Coroner.)

Mar 9 191 (Address) 2632 Rolandson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Mar 10, 17

20-UNDERTAKER W B Cook

ADDRESS 502 E Balto

D 9932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9932

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E. Hulcher

(Residence in Baltimore: No. Belair Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 10 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clinton E. Hulcher

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Tinker

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital Records

(Address) W. Lombard St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull Caused by Gas Tank, & Bleeding in the Brain Accident (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. mos. ds.

(Signed) A. L. Doscher M. D.
(Coroner)

Nov 9., 191.. (Address) 211 W. Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Bel. Air. Md. DATE OF BURIAL, Nov. 10, 1917

20-UNDERTAKER: Stewart & Mowen Co ADDRESS 108 W. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS must not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9933

CERTIFICATE OF DEATH.

28 D 9933

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 3120 Fait ave. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Brady

(Residence in Baltimore: No. 3120 Fait ave. St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1890 (Year)

7-AGE,	If LESS than 1 day,
27 yrs. 9 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION;
(a) Trade, profession, or particular kind of work..... Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)..... 059

333

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, John T. Brady

11-BIRTHPLACE OF FATHER (State or Country), N.Y.

12-MAIDEN NAME OF MOTHER Lucy Smith

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Brady Jr.

(Address) 3120 Fait ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1917, to Nov 7 1917, that I saw h— alive on Nov 7 1917, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) .. yrs. ..... mos. 3 ds.

(Signed) John G. Downes M.D.

Nov 9, 191.7 (Address) Gorman & Mt. Prospect

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem.

DATE OF BURIAL, Nov 10, 191.7

20-UNDERTAKER John A. Inoran

ADDRESS 3000 E Baltimore

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION IS VERY important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be

NOV 10 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9931

CERTIFICATE OF DEATH.

89 D 9931

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N Elwood ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Ester Zanza - (Zanza)

(Residence in Baltimore: No. 143 N Elwood ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Wht

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) S.

6-DATE OF BIRTH, Oct (Month) 8th (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Non
(b) General nature of industry, business, or establishment in which employed (or employer) 100

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, Salvatore Zanza

11-BIRTHPLACE OF FATHER (State or Country), Italy -

12-MAIDEN NAME OF MOTHER Argata Giardina.

13-BIRTHPLACE OF MOTHER (State or Country), Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Zanza

(Address) 143 N. Elwood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-1-1917, to 11-9-1917, that I saw h- alive on 11-8 1917, and that death occurred, on the date stated above, at 5-9. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) ....yrs. ....mos. 10 ds.

(Signed) S. J. Moran M. D.

11-9, 1917. (Address) 1104 Linden ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Bem

DATE OF BURIAL, Nov 10, 1917.

20-UNDERTAKER John A. Moran

ADDRESS 3000 E. Baltimore

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9935

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2943 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Sprole (Sprole)

(Residence in Baltimore: No. 2943 Hudson St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day), 1 (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer). Grocery

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER. John Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Ire.

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Ire.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Sprole

(Address) 2932 Hudson St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Nov 8 1917, that I saw h er alive on Nov 7 1917, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) about 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) M. F. Mcavoy M. D.

Nov 8, 1917. (Address) 539 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Nov 12, 1917.

20-UNDERTAKER John A. Inman ADDRESS 3000 E. Baltimore St.

N. B.—Every item of information called for must be given, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9936

CERTIFICATE OF DEATH.

+1 D 9936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Worley

(Residence in Baltimore: No. Md. School for Boys St.; ....yrs,, ...mos. ....ds.)

N. B.—Every item of information must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, September 9, 1901
(Month) (Day) (Year)

7-AGE, 16 yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Frank Woorley

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Gertrude Stalken

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Klein

(Address) 1113 Woorley St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 191 7, to Nov 9 191 7, that I saw him alive on Nov 9 191 7, and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

1 Typhoid Fever

2

3

.....(Duration) ....yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Septic Meningitis

.....(Duration) ....yrs. ....mos. 5 ds.

(Signed) Edward L Dunn M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3½ ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Md. School for Boys

Former or usual residence " " "

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Nov 12, 191...
20-UNDERTAKER Wm Cook	ADDRESS 822 E. Mad

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9937

CERTIFICATE OF DEATH.

X 113 D 9937

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Whitley

(Residence in Baltimore: No. 7 Davis St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 11, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 5 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 320
(a) Trade, profession, or particular kind of work Miller
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, John Whitley

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Elizabeth Saltzman

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

N. B.—Every item of information called for in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1917, to Nov. 9 1917, that I saw h alive on November 9 1917, and that death occurred, on the date stated above, at 11 30 pm.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hepatic Coma

(Duration) yrs. 7 mos. ds.

(Signed) C. H. Mayo M. D.

Nov. 10, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bell Haven N.C.

19-PLACE OF BURIAL OR REMOVAL, Pantego N. C. DATE OF BURIAL, Nov. 10, 1917.

20-UNDERTAKER Albert C Fuller ADDRESS 221 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 0938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 0938

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Mansfield ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmer G. Shilow

(Residence in Baltimore: No. 805 Mansfield St.; ....yrs., 2 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 15th, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Raymond T. Shilow

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lillian McKey

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond T. Shilow

(Address) 805 Mansfield St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 9 1917, that I saw h[illegible] alive on Nov. 9 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration)....yrs....mos. 3 ds.

(Signed) Shepherd Dorsey M. D.

Nov. 10, 1917. (Address) 122 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov. 12th 1917.

20-UNDERTAKER E. McCormick & Son ADDRESS 1039 Hanover St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause is important. See instructions on back of certificate.

12
8 20

Ernesto Giocconi

HEALTH DEPARTMENT—CITY OF BALTIMORE

F 7 D 9939

CERTIFICATE OF DEATH.

156 D 9939

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 638 W. Franklin ST. 17 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernesto Giocconi

(Residence in Baltimore: No. New York St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... September ....., 1867
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. September

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Store

766 1086

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Edmondo

(Address) New York

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 9 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Thrombosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Nov. 10, 191.. (Address) 8 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Nov. 11, 191.

20-UNDERTAKER J. J. Curran & Son ADDRESS 901 Holliday

N. B.—Every item of information should be carefully supplied. ACE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17
3 8
7 9 D 9940

Nellie Giacomi

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 156 D 9940

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 638 N. Franklin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Giacomi

(Residence in Baltimore: No. 638 N. Franklin St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, September 18 1878
(Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Opera Singer 086
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Luigi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Lucia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine

(Address) 638 N. Franklin

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Duration 1 day

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. J. McGowan M. D.
(Coroner.)
Nov. 11, 191... (Address) 1719 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Edmondson Ave. DATE OF BURIAL, Nov. 11, 1917

20-UNDERTAKER J. J. Cowan & Son ADDRESS 901 Baltimore St.

N.B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Annie Gold

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D. 9941

CERTIFICATE OF DEATH.

104 D 9941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Hosp. St. in ... WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Annie Gold.

(Residence in Baltimore: No. 211 Aisquith St.; 26 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 188[illegible] (Year)

7-AGE, 29 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Levin

(Address) 1411 E Baltimore

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1917, to November 9 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(Post Op.)

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Gall stone operation

(Duration) ... yrs. ... mos. ... ds.

(Signed) J W Foster M. D.

..., 191... (Address) Garrett Bldg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 1 mos. 11 ds. In the State X yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? XX

Former or usual residence 211 Aisquith St., Balto.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, Nov 11, 1917

20-UNDERTAKER Jack Levin

ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9912

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 S. Carlin ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tillie Bullock (Pullock)

(Residence in Baltimore: No. 213 S. Carlin St.; 17 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Unknown, (Month) (Day) 1878 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 191 7, to Nov 10 191 7, that I saw h-r alive on Nov 10 191 7, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Gangrene

(Duration) 7 yrs. mos. 2 ds.

(Signed) Israel Feinberg M. D.

Nov 10, 191 7 (Address) 1411 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington D | DATE OF BURIAL, 11/10, 191 7

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103

D 9913

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Penn Av. St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Franklin

(Residence in Baltimore: No. 2608 Penn Av St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1845 (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook 021
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Private Family

9-BIRTHPLACE, (State or Country), Arlington Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Franklin

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Mason

(Address) 1317 Woodyear Pl.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 8 1917, that I saw h[illegible] alive on Nov 8 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Atheroma Nov 7 of Brain

& pulmonary tuberculosis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Pole M. D.

Nov 8, 191.. (Address) 2031 Madison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov 11, 191.7

20-UNDERTAKER Samuel Hawley

ADDRESS 5 Blo Bdle

P. S. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9941 — 154 — D 9941

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 846 Reinhart ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Schenkel

(Residence in Baltimore: No. 846 Reinhart St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, Feb 22, 1845
(Month) (Day) (Year)

7-AGE, 72 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Peddler
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Schenkel

(Address) 846 Reinhart

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause unk

(Duration) yrs. mos. ds.

(Signed) F. Edw Smith M. D.
(Coroner)

Nov 10, 191 7. (Address) Raleigh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery

DATE OF BURIAL, Nov 13, 1917

20-UNDERTAKER William Cook

ADDRESS 600 N Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9945

CERTIFICATE OF DEATH.

6 42 D 9945

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Ann St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Harning

(Residence in Baltimore: No. 140 N. Ann St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Widow

6-DATE OF BIRTH, Feb. 13, 1846.
(Month) (Day) (Year)

7-AGE, 70 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Switzerland

PARENTS.

10-NAME OF FATHER, Ulrich Salzer

11-BIRTHPLACE OF FATHER (State or Country), Switzerland

12-MAIDEN NAME OF MOTHER Dont Known

13-BIRTHPLACE OF MOTHER (State or Country), Switzerland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Harning

(Address) 140 N. Ann St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1917, to Nov 9 1917, that I saw her alive on Nov 8 1917, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Ulcers Cancer

CAN

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Wootten M. D.

Nov 9, 191... (Address) 16 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakdale. DATE OF BURIAL, Nov. 12, 1917.

20-UNDERTAKER Wm Cook & Co. ADDRESS 502 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

D 9946

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9946

1 PLACE OF DEATH

REGISTERED NO. C 28

CITY OF BALTIMORE (No. 214 N Fredrick ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Stwart

(Residence in Baltimore: No. 214 N. Fredrick St.: 25 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: July (Month) 16, (Day) 1870 (Year)

7-AGE: 47 yrs. 3 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): City Electric dept.

9-BIRTHPLACE (State or country): Wash. D.C.

PARENTS

10-NAME OF FATHER: James A. Stwart

11-BIRTHPLACE OF FATHER (State or country): Pa.

12-MAIDEN NAME OF MOTHER: Margaret Bright

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fannie Stwart

(Address) 214 N. Frederick St

15

Filed ....., 191 .....

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 10 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2d, 191?, to. Nov. 9 1917, that I saw him alive on Nov. 9, 1917, and that death occurred, on the date stated above, at 9.00 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds

Contributory (SECONDARY) Broncho pneumonia

(Duration) yrs. mos. 5 ds.

(Signed) Benj. Keadry M. D.

Nov. 10, 1917 (Address) 252 N. Payson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Lucies Cemetery

DATE OF BURIAL: Nov 12, 191?

20-UNDERTAKER: William Cook

ADDRESS: 507 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womens Hospital

REGISTERED NO. C 111 ✓ D 9947

CITY OF BALTIMORE: (No. ..... St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Ellen Duvall

(Residence in Baltimore: No. 1114 N. Eutaw St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 1 (Day), 1841 (Year)

7-AGE, 76 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Dr Marine Duvall

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Harriet Evans

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Eleanor D Brown

(Address) 1402 Park Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Nov 10, 1917, that I saw h er alive on 11/10 1917, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

d

Clinical (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of bowel

Carcinoma of bowel (Duration) ..... yrs. 5 mos. ..... ds.

(Signed) Felix M. Clark M. D.

Nov. 10, 191 7. (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State 76 yrs. 5 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1114 N Eutaw St

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov. 12, 1917

20-UNDERTAKER John O Mitchell

ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

NOV 11 1917 ROBERT R. STAUFER Registrar

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9948

1 PLACE OF DEATH

REGISTERED NO. C D 9948

CITY OF BALTIMORE (No 2549 N. North ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude I. Cady

(Residence in Baltimore: No. 2549 N. North ave St.: 10 yrs. about mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: June 27, 1897 (Month) (Day) (Year)

7-AGE: 20 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

199

9-BIRTHPLACE (State or country): New York City

PARENTS

10-NAME OF FATHER: William Cady

11-BIRTHPLACE OF FATHER (State or country): Washington D.C.

12-MAIDEN NAME OF MOTHER: Marion Mollineux

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Marion Cady

(Address) 2549 N. North av

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1917, to Nov. 8 1917.

that I saw h[illegible] alive on Oct. 29, 1917.

and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. about mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) John E. O'Neill M. D.

Nov 10, 1917 (Address) 2565 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral

DATE OF BURIAL: Nov 12th, 1917

20-UNDERTAKER: John F. Fields

ADDRESS: 1200 W. Lombard St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9949

CERTIFICATE OF DEATH.

120 D 9949

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 16 W. Strieker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James. R. Keller

(Residence in Baltimore: No. 16 W. Strieker St. 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 18, 1839
(Month) (Day) (Year)

7-AGE, 78 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, William Keller

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa E. Keller

(Address) 16 W. Strieker St

15-

Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1917, to Nov 10 1917, that I saw h alive on Nov 7, 1917, and that death occurred, on the date stated above, at 3 25 m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) My records show

(Duration) yrs. 6 mos. 8 ds.

(Signed) James R Keller M. D.

Nov 10, 1917. (Address) 1729 E Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Piedmont W. Va. DATE OF BURIAL, Nov 12, 1917.

20-UNDERTAKER Jos Jacobs & Son ADDRESS 217 S. Pa

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9950

CERTIFICATE OF DEATH.

29 ✓ D 9950

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1805 Frederick ave St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Depser

(Residence in Baltimore: No. 1805 Frederick ave. St.; Lyke time mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, May (Month) 14 (Day), 1889 (Year)

7-AGE, 28 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer)..... 666 Ave

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Fred K Depser

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Pastorius

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Depser

(Address) 1805 Frederick Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Nov 10 1917, that I saw h[er] alive on Nov 9 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(Duration) ..... yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebro-Spinal Meningitis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) E. V. Cookelaus M. D.

11/11/17, 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem DATE OF BURIAL, Nov 13, 1917

20-UNDERTAKER Geo A Kerby ADDRESS Balto Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9951

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Hollins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel J. Boyd

(Residence in Baltimore: No. 1226 Hollins St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March 30, 1850
(Month) (Day) (Year)

7-AGE, 66 yrs. 7 mos. 8 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Samuel Boyd

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Owen

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J. Boyd Jr.

(Address) 1226 Hollins St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1917, to Nov 8 1917, that I saw him alive on Nov 8 1917, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

1. Hypostatic Pneumonia

.....

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) Unknown yrs. ....mos. ....ds.

(Signed) W A Powell M. D.

Nov 10., 191 7. (Address) 108 N Bulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Nov 12 1917

20-UNDERTAKER Leo A Zerby

ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 9952

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 S. Sharp ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Vince

(Residence in Baltimore: No. 409 S. Sharp St.; 8 yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1868
(Month) (Day) (Year)

7-AGE, 49 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Joseph Vince

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Sarah Gelrosa

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Vince

(Address) 521 Colvin St.

15-

NOV 11 1917 ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November, 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct, 10 1917, to Nov, 10 1917, that I saw her alive on Nov, 9, 1917, and that death occurred, on the date stated above, at 12,30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

..... (Duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) David Franchini M. D.

11/10, 1917 (Address) 122 W Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Nov. 12, 1917.
20-UNDERTAKER	**ADDRESS**
John J Laheyson	1318 Lightst

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9953

CERTIFICATE OF DEATH.

44 D 9953

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 W. Baltimore ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Finegan

(Residence in Baltimore: No. 2000 W. Baltimore St. St.: ....yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Don't Know ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, about 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Butler Regenald .....

(Address) 2000 W Balto St .....

15-

Filed....., 191.....

Registrar.

NOV 11 1917 ROBERT R. KRAUTER

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Nov 10 1917, that I saw h~ alive on Nov 10 1917, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Chronic Endocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) E. V. Cornbrooks, M. D.

11/10/17, 191... (Address) 24 E Fulton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Wilmington Del — DATE OF BURIAL, Nov 12, 1917

20-UNDERTAKER, Chas F. Evans & Son — ADDRESS 118 W Mt Royal

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9951

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Fox (Dear 7)

(Residence in Baltimore: No. 3921 Fait ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	married

6-DATE OF BIRTH. June 4, 1866
(Month) (Day) (Year)

7-AGE. 51 yrs. 5 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Time keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country): Maryland.

PARENTS.

10-NAME OF FATHER. Wm H. Fox

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER Julia Triggs

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) [illegible]

15-

Filed ....., 191.....
Registrar.

ROBERT R. KNAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 2 1917, to November 11 1917, that I saw him alive on Nov. 11 1917, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma prostate

other

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) ? yrs. mos. ds.

(Signed) Edwin F. Fox M. D.

Nov. 11, 191... (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3921 Fait Ave

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, Nov. 14, 191.7.

20-UNDERTAKER Wm Cook ADDRESS 1502 E. Monument

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 9955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9955

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1013 Bennett Place ST., 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jamie Allucisi

(Residence in Baltimore: No. 1013 Bennett Place St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widow

6-DATE OF BIRTH, ... Aug (Month) ..... 23 (Day), 1834 (Year)

7-AGE,	If LESS than 1 day,
83 yrs. 7 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Christopher Talbot

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane Doyle

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. Conroy

(Address) 1013 Bennett Place.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) ....., 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

11/10...., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 12, 1917

20-UNDERTAKER E. A. Rudderow — ADDRESS Greenmount Ave.

N. B.—Every item of information must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 9956

CERTIFICATE OF DEATH

97

D 9956

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N. Fayette St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Thompson

(Residence in Baltimore: No. 707 N. Fayette St.; 25 yrs. ..... mos. ..... ds.)

N. B.—Every item must be answered so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: July (Month) 22 (Day), 1866 (Year)

7-AGE: 51 yrs. 3 mos. 17 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Stage Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE (State or country): California

PARENTS

10-NAME OF FATHER: Jno. C. Thompson

11-BIRTHPLACE OF FATHER (State or country): California

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): California

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Horace J. Thompson

(Address) 707 N. Fayette St.

15-

NOV 11 1917 ROBERT R. KRAUTER

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 191 7, to, Nov 9 191 7, that I saw h[illegible] alive on Nov 8 191 7, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs 6 mos. ds.

Contributory (SECONDARY) Arterio Sclerosis

(Duration) yrs. mos. 12 ds.

(Signed), Harry Boyd M. D.

Nov 10, 191 7 [Address] 612 Columbia

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov 13 191 7

20-UNDERTAKER: Graham Walker — ADDRESS: 1132 E. Fayette

D 9957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9957

CERTIFICATE OF DEATH.

19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020. St. Paul ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James S. Woodside

(Residence in Baltimore: No. 1020, St. Paul St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	widower

6-DATE OF BIRTH, June 23rd, 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Commission 045
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm S Woodside

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Rachel Beaty.

13-BIRTHPLACE OF MOTHER (State or Country), maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr R Wolfgill

(Address) 1020 St Paul St

15-

Filed....., 191.....

Registrar.

NOV 11 1912 ROBERT R. KRAUTER Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1917, to Nov 9th 1917, that I saw him alive on November 9th 1917, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral and Aortic
Insufficiency
Senile
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr. T. Lockwood M. D.

Nov 10th 1917 (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Nov 12, 1917.
20-UNDERTAKER Graham F. Walker	ADDRESS 123 Whs

D 9958

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 D 9958

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 624 - E. Fort Ave. St.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jacob Mathias Hartman

(Residence in Baltimore: No. 624 E. Fort ave. St.: 40 yrs. ..... mos. ..... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) ..... (Day), 1860 (Year)

7 AGE: 57 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: R.R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): Freight 073

9 BIRTHPLACE (State or country): Frederick, Md.

PARENTS

10 NAME OF FATHER: Jno. Hartman

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. D. Hartman

(Address) 624 E. Fort Ave.

15 Filed ..... , 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 9th (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May ..... 191 7 . to. Nov. 8th 191 7.

that I saw him alive on Nov. 8th 191 7.

and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) 7 yrs. 6 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank D. Doyle M. D.

11/9, 191 7 (Address) 3 E. Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Nov. 12, 191 7

20 UNDERTAKER: W. G. F. Gunn ADDRESS: 1402 Light

NOV 11 1917 ROBERT B. KRAUTER

D 9959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1918 ✓

D 9959

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hannamans Hosp ST.: 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Treva Gingling.

3-(Residence in Baltimore: No. 848 N 33 st

St. 17 yrs., 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 16 (Day), 1900 (Year)

7-AGE, 17 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Leonard J. Gingling

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice Hoefeld

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Walker

(Address) 848 N. 33 st.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest & autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abortion

(Criminal)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Edwin Smith M. D.
(Coroner)

Nov 11, 1917 (Address) 710 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Marys Hampden	Nov. 12. 1917
20-UNDERTAKER	ADDRESS
Chenowith & Son	3617 Chestnut ave.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

NOV 11 1917 ROBERT R. KRAUTER
Registrar of Vital Statistics

Spec.—8-24-14—M. & T.—2000 Bks.

D 9960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9960

CERTIFICATE OF DEATH.

47

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 Pierce ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Harper

(Residence in Baltimore: No. 935 Pierce St.; 74 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	widow

6-DATE OF BIRTH, Dont Know (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
54 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Cathe Rich

(Address)..... 935 Pierce st

15-

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1917, to Nov 8 1917, that I saw h[illegible] alive on Nov 8 1917, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriolar Sclerosis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) [illegible] M. D.

Nov 10, 1917 (Address) 1465 N Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mont Auburn	Nov 12, 1917

20-UNDERTAKER	ADDRESS
John E Owens	5-38 Dolphin st

CAUSE OF DEATH to be filled in plain terms, so that a non-medical person may understand it. Name of disease alone insufficient. Indefinite terms, such as "Debility," "Old Age," "Exhaustion," "Convulsions," "Fever," "Inflammation," "Congestion," "Hemorrhage," "Abscess," "Cancer," "Tumor," "Ulcer," "Tuberculosis," "Consumption," "Malignant Disease," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Peritonitis," "Pneumonia," "Bronchitis," "Pleurisy," "Heart Disease," "Valvular Disease," "Kidney Disease," "Bright's Disease," "Cirrhosis," "Jaundice," "Gastritis," "Enteritis," "Colitis," "Hernia," "Appendicitis," "Obstruction," "Stricture," "Fracture," "Dislocation," "Injuries," "Shock," "Hemorrhage," "Asphyxia," "Suffocation," "Drowning," "Burns," "Scalds," "Poisoning," "Abortion," "Childbirth," "Puerperal Fever," "Premature Birth," "Stillbirth," "Infantile Diseases," "Teething," "Marasmus," "Inanition," "Starvation," "Cholera Infantum," "Spasms," "Convulsions," "Lockjaw," "Tetanus," "Hydrophobia," "Rabies," "Paralysis," "Apoplexy," "Cerebral Hemorrhage," "Softening of Brain," "Congestion of Brain," "Epilepsy," "Insanity," "Suicide," "Homicide," "Accident," "Sudden Death," "Unknown," "Not Known," "Not Ascertained," "Not Given," "Not Stated," "Not Specified," "Not Certified," "Not Diagnosed," "Not Determined," "Not Known," "Not Ascertained," "Not Given," "Not Stated," "Not Specified," "Not Certified," "Not Diagnosed," "Not Determined," are not sufficient. Be sure to state the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9961

CERTIFICATE OF DEATH.

91

REGISTERED NO. C 9961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Dallas ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie M Marrow

(Residence in Baltimore: No. 1618 N Dallas St. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 11, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Non
(b) General nature of industry, business, or establishment in which employed (or employer). Non

9-BIRTHPLACE, (State or Country), born in Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Marrow

11-BIRTHPLACE OF FATHER (State or Country). Clarksville Va

12-MAIDEN NAME OF MOTHER Martha Gales

13-BIRTHPLACE OF MOTHER (State or Country), Clarksville Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) mother Martha Marrow

(Address) 1618 N Dallas St

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH must be stated plainly and fully. Use no abbreviations or terms not understood generally. Indefinite statements, such as "Disease of the heart," "Tumor," "Fever," "Cancer," "Consumption," "Old age," "Infirmities of age," "Dropsy," "Convulsions," "Childbirth," "Debility," "Paralysis," "Abscess," "Inflammation," "Hemorrhage," "Ulceration," "Blood poisoning," "Malignant disease," "Septicemia," "Pyemia," "Uremia," "Gangrene," "Meningitis," "Pneumonia," "Bronchitis," "Pleurisy," "Peritonitis," "Enteritis," "Colitis," "Nephritis," "Cystitis," "Hepatitis," "Jaundice," "Hydrocephalus," "Marasmus," "Tuberculosis," "Scrofula," "Rheumatism," "Neuralgia," "Locomotor ataxia," "Epilepsy," "Apoplexy," "Cerebral hemorrhage," "Cerebral softening," "Cerebral congestion," "Cerebral apoplexy," "Cerebral embolism," "Cerebral thrombosis

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9962

CERTIFICATE OF DEATH.

64 D 9962

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 215 N Spring ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Molly Boston

(Residence in Baltimore: No. 215 N. Spring St St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, Thomas F. Foster

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jinnie May

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Buttie Boston

(Address) 215 N. Spring St

15-

Filed ....., 191.....

Registrar.

NOV 12 1917 HARRY O. IN REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Nov 8 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

(a) [illegible]

(b) Apoplexy

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 8, 191... (Address) 115 N Spring

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov 12, 191.

20-UNDERTAKER R. S. Ford

ADDRESS 1405 McCulloh St

CAUSE OF DEATH must be stated in full. Indefinite terms, such as "Old Age," "Debility," "Exhaustion," "Heart Failure," "Convulsions," "Paralysis," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Consumption," "Dropsy," "Cholera," "Cholera Infantum," "Teething," "Premature Birth," "Marasmus," "Stillborn," "Lockjaw," "Mortification," "Gangrene," "Ulceration," "Sudden Death," "Found Dead," "Suicide," "Accident," "Homicide," "Killed," "Burned," "Drowned," "Fractured Skull," "Injuries," "Shock," "Hemorrhage," "Internal Hemorrhage," "Congestion," "Syncope," "Coma," "Uremia," "Blood Poisoning," "Septicemia," "Pyemia," "Meningitis," "Tuberculosis," "Tuberculosis of Lungs," "Tuberculosis of Brain," "Tuberculosis of Bowels," "Tuberculosis of Peritoneum," "Tuberculosis of Spine," "Tuberculosis of Joints," "Tuberculosis of Glands," "Tuberculosis of Kidneys," "Tuberculosis of Bones," "Tuberculosis of Skin," "Tuberculosis of Liver," "Tuberculosis of Spleen," "Tuberculosis of Heart," "Tuberculosis of Pancreas," "Tuberculosis of Stomach," "Tuberculosis of Intestines," "Tuberculosis of Rectum," "Tuberculosis of Anus," "Tuberculosis of Genitals," "Tuberculosis of Urinary Organs," "Tuberculosis of Reproductive Organs," "Tuberculosis of Nervous System," "Tuberculosis of Circulatory System," "Tuberculosis of Respiratory System," "Tuberculosis of Digestive System," "Tuberculosis of Excretory System," "Tuberculosis of Endocrine System," "Tuberculosis of Lymphatic System," "Tuberculosis of Skeletal System," "Tuberculosis of Muscular System," "Tuberculosis of Integumentary System," "Tuberculosis of Sensory System," "Tuberculosis of Special Senses," "Tuberculosis of Eyes," "Tuberculosis of Ears," "Tuberculosis of Nose," "Tuberculosis of Throat," "Tuberculosis of Mouth," "Tuberculosis of Teeth," "Tuberculosis of Tongue," "Tuberculosis of Salivary Glands," "Tuberculosis of Pharynx," "Tuberculosis of Larynx," "Tuberculosis of Trachea," "Tuberculosis of Bronchi," "Tuberculosis of Lungs," "Tuberculosis of Pleura," "Tuberculosis of Mediastinum," "Tuberculosis of Diaphragm," "Tuberculosis of Abdominal Wall," "Tuberculosis of Peritoneum," "Tuberculosis of Omentum," "Tuberculosis of Mesentery," "Tuberculosis of Retroperitoneal Tissues," "Tuberculosis of Kidneys," "Tuberculosis of Ureters," "Tuberculosis of Bladder," "Tuberculosis of Urethra," "Tuberculosis of Prostate," "Tuberculosis of Testes," "Tuberculosis of Epididymis," "Tuberculosis of Vas Deferens," "Tuberculosis of Seminal Vesicles," "Tuberculosis of Penis," "Tuberculosis of Scrotum," "Tuberculosis of Ovaries," "Tuberculosis of Fallopian Tubes," "Tuberculosis of Uterus," "Tuberculosis of Vagina," "Tuberculosis of Vulva," "Tuberculosis of Mammary Glands," "Tuberculosis of Breast," "Tuberculosis of Nipple," "Tuberculosis of Areola," "Tuberculosis of Axillary Lymph Nodes," "Tuberculosis of Supraclavicular Lymph Nodes," "Tuberculosis of Cervical Lymph Nodes," "Tuberculosis of Inguinal Lymph Nodes," "Tuberculosis of Femoral Lymph Nodes," "Tuberculosis of Popliteal Lymph Nodes," "Tuberculosis of Mesenteric Lymph Nodes," "Tuberculosis of Retroperitoneal Lymph Nodes," "Tuberculosis of Thoracic Lymph Nodes," "Tuberculosis of Abdominal Lymph Nodes," "Tuberculosis of Pelvic Lymph Nodes," "Tuberculosis of Lumbar Lymph Nodes," "Tuberculosis of Sacral Lymph Nodes," "Tuberculosis of Coccygeal Lymph Nodes," "Tuberculosis of Lymphatic Vessels," "Tuberculosis of Lymphatic Ducts," "Tuberculosis of Lymphatic Trunks," "Tuberculosis of Lymphatic Plexuses," "Tuberculosis of Lymphatic Capillaries," "Tuberculosis of Lymphatic Sinuses," "Tuberculosis of Lymphatic Nodules," "Tuberculosis of Lymphatic Follicles," "Tuberculosis of Lymphatic Tissue," "Tuberculosis of Lymphatic Organs," "Tuberculosis of Lymphatic

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9963

CERTIFICATE OF DEATH.

120

D 9963

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Crim

(Residence in Baltimore: No. 1809 W. Mulberry St.; 52 yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... (Month) June (Day) 1 (Year) 1865

7-AGE, 52 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Henry C. Mercier.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary J. Sauk

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Mercer.

(Address) 1809 W. Mulberry

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/24 1917, to 11/11 1917, that I saw her alive on 11/11 1917, and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) ..... yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic tubercular

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11/11, 191.7 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 8 ds. In the State 52 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Balto. Md.

Former or usual residence 1809 W. Mulberry St. Balto. Md.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov. 14, 1917

20-UNDERTAKER Wm Coale

ADDRESS 502 E. Mon

CAUSE OF DEATH must be given in plain terms. Indefinite or unsatisfactory answers will not be registered. Such terms as Heart Disease, Cancer, Tumor, Stroke, Fever, Cancer, Consumption, Dropsy, Cancer, Kidney Disease, Old Age, Cancer, Paralysis, Cancer, Convulsions, Cancer, Childbirth, Cancer, Abscess, Cancer, Unknown, Cancer, are wholly insufficient. Cancer, Cancer, Cancer,

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D 9961 HEALTH DEPARTMENT—CITY OF BALTIMORE D 9961

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Manning

(Residence in Baltimore: No. 19 N Frederick St ST.: 113

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	single

6-DATE OF BIRTH, ... Unknown (Month) ..... (Day) 1874 (Year)

7-AGE, 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Manning

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Coyle

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hosp Data

(Address) Gilmor & Lombard

15-

Filed ....., 191.....

Registrar.

CAUSE OF DEATH. This line must be filled out. If the cause is not known, state the fact. If the death was due to external causes, state the accident, suicide or homicide, and the means of injury, and whether it occurred while at work. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/14 191 7, to 11/9 191 7, that I saw him alive on 11/9 191 7, and that death occurred, on the date stated above, at 6 15 a m.

The CAUSE OF DEATH* was as follows:

Emphysema of Right Lung

(Duration) ..... yrs. ..... mos. 70 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Leff M. D.

11/12, 191 7. (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 80 ds. In the State 43 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 19 N Frederick St

Former or usual residence 19 N Frederick St.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Nov 12 1917

20-UNDERTAKER Wm Loatz

ADDRESS 502 E Wells

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9965

D 9965

CERTIFICATE OF DEATH.

152

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Eager Place ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Morgoni

(Residence in Baltimore: No. 2532 E Eager Place St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 11, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frank Morgoni

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosie Genny

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Morgoni

(Address) 2532 Eager Place

15-

Filed NOV 12 1917, 191.... HARRY O. ANDREWS Registrar.

CAUSE OF DEATH must be filled in plainly and completely. Use both Medical and Lay terms. Underlining makes important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 191.., to Nov 12 17 191..,
that I saw h[illegible] alive on Nov 12 17. 191..,
and that death occurred, on the date stated above, at 5A. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Newman M. D.

Nov 12 17 191... (Address) 1508 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Patricks Cem

DATE OF BURIAL, Nov 12, 1917.

20-UNDERTAKER Jos Henig & Co

ADDRESS 2008 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D 9966

HEALTH DEPARTMENT—CITY OF BALTIMORE

67 D 9966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 718 S. Eden ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Vollrath

(Residence in Baltimore: No. 718 S. Eden St.; 72 yrs., 10 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED,~~ Married (Write the word.)

6-DATE OF BIRTH, Dec 12, 1844 (Month) (Day) (Year)

7-AGE, 72 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedor
(b) General nature of industry, business, or establishment in which employed (or employer): 074

504

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Christian Vollrath

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Vollrath

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Vollrath

(Address) 718 S. Eden St

15-

Filed....., 191.....

Registrar.

NOV 12 1917 HARRY O. ANDERSON Registrar of Vital Statistics

CAUSE OF DEATH. Items must be carefully considered and answered in accordance with instructions on back of certificate. Every question must be answered or the certificate will be returned. Be particularly careful to fill items 16 and 17 correctly and to state the cause of death in such terms as will show the disease primarily causing death, or in deaths from violence, the nature of injury. Indefinite and unsatisfactory terms of cause of death, such as "Heart Failure," "Asthenia," "Senility," "Old Age," "Cancer," "Tumor," "Abscess," "Child-birth," "Accident," "Fracture," "Injuries," "Operation," "Hemorrhage," "Convulsions," "Uremia," "Debility," "Exhaustion," "Septicemia," "Pyemia," "Blood Poisoning," "Malignant Disease," "Meningitis," "Inflammation," "Pneumonia," "Bronchitis," "Pleurisy," "Colitis," "Enteritis," "Nephritis," "Kidney Disease," "Liver Disease," "Gastritis," "Hepatitis," "Jaundice," "Diarrhea," "Dysentery," "Hernia," "Obstruction," "Ulceration," "Perforation," "Gangrene," "Embolism," "Thrombosis," "Valvular Disease," "Aneurism," "Rupture," "Paralysis," "Apoplexy," "Epilepsy," "Locomotor Ataxia," "Spinal Disease," "Spinal Irritation," "Tetanus," "Lockjaw," "Cholera Morbus," "Cholera Infantum," "Marasmus," "Inanition," "Premature Birth," "Stillborn," "Congenital Debility," "Malformation," "Monstrosity," "Still," "Unknown," "Unascertained," "Undetermined," "Not Known," "Not Ascertained," "Not Determined," "Not Known to Informant," "Not Known to Informant and Unascertained," "Not Known to Informant and Undetermined," "Not Known to Informant and Not Ascertained," "Not Known to Informant and Not Determined," "Not Known to Informant and Unascertained and Undetermined," "Not Known to Informant and Unascertained and Not Determined," "Not Known to Informant and Undetermined and Not Determined," "Not Known to Informant and Unascertained and Undetermined and Not Determined," "Not Known to Informant and Unascertained and Undetermined and Not Determined and Not Known to Informant," "Not Known to Informant and Unascertained and Undetermined and Not Determined and Not Known to Informant and Unascertained," "Not Known to Informant and Unascertained and Undetermined and Not Determined and Not Known to Informant and Unascertained and Undetermined," "Not Known to Informant and Unascertained and Undetermined and Not Determined and Not Known to Informant 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Determ

D 0967

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 0967

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 317 Reisterstown Rd St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ivan Pala

(Residence in Baltimore: No. 317 Reisterstown Rd St.; 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec 8, 1867 (Month) (Day) (Year)

7-AGE: 47 yrs 11 mos 2 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Grocery
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE (State or country): Italy

PARENTS

10-NAME OF FATHER: Phillip Pacallari

11-BIRTHPLACE OF FATHER (State or country): Italy

12-MAIDEN NAME OF MOTHER: Mariano Tenne

13-BIRTHPLACE OF MOTHER (State or country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ivan B. Pala

(Address) 317 Reisterstown Rd

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Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1917, to, Nov 10 1917, that I saw h.. alive on Nov 10 1917, and that death occurred, on the date stated above, at 8 50 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) yrs 6 mos — ds.

Contributory (SECONDARY) Tuberculosis pulmonary ?

..... (Duration) ? yrs mos ds.

(Signed) John B Burbert M. D.

Nov 11 1917 [Address] 4504 Park Heights Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Nov 13th 1917

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 W Baltimore St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificate.

NOV 12 1917 MARY O. ANDREWS

D 9968

HEALTH DEPARTMENT--CITY OF BALTIMORE

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D 9968

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 112 E Gittings ST. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Olivia F Cook

(Residence in Baltimore: No. 112 E Gittings St.; 29 yrs. 7 mos. 20 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. Information at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX ~~SEX~~ Female

4-COLOR OR RACE White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH March 21, 1888 (Month) (Day) (Year)

7-AGE 29 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Balto

PARENTS

10-NAME OF FATHER Richard W Hall

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Susan E Spicer

13-BIRTHPLACE OF MOTHER (State or country) Orchard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard J Hall

(Address) 112 E Gittings

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Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov 10 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 25th, 1917, to, Nov 10th 1917, that I saw h-e alive on Nov 10th 1917, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pneumothorax (Duration) ..... yrs. 2 mos. ..... ds

Contributory (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F B Holt M. D.

Nov 12th, 1917 (Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Nov 14, 1917

20-UNDERTAKER Thos J E Evans & Son

ADDRESS 1428 & 30 Charles St

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Spec.—8-24-14—M. & T.—2000 Blks.

D 9969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9969

CERTIFICATE OF DEATH.

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1-PLACE OF DEATH Church Home Infirmary REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2103 Lake Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr William Lewis

(Residence in Baltimore: No. 2103 Lake Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 17, 1874 (Month) (Day) (Year)

7-AGE, 43 yrs. 5 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman 920
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Baking Co.

9-BIRTHPLACE, (State or Country), Ky.

PARENTS.

10-NAME OF FATHER, Hunter Lewis

11-BIRTHPLACE OF FATHER (State or Country), Ky.

12-MAIDEN NAME OF MOTHER, Catherine Worden

13-BIRTHPLACE OF MOTHER (State or Country), Ky.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lewis

(Address) 2103 Lake Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Nov 11 1917, that I saw him alive on Nov 11 1917, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

Chronic Appendicitis (Operation)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) mos. 2 ds.

(Signed) [redacted] M. D.

Nov 11, 1917 (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 11 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2103 Lake Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 14, 1917

20-UNDERTAKER J. F. Rukwood Sons ADDRESS Monument

NOV 12 1917 HARRY O. ANDREWS Burial Permit

Cause of death may be important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9970

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1231 Presbury St. Ward 15)

REGISTERED No. C 120 D 9970

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Snowbella Frazell.

(Residence in Baltimore: No. 1231 Presbury St. St. 20 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female. 4-COLOR OR RACE: white. 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: June (Month) 2 (Day), 1862 (Year)

7-AGE: 55 yrs. 5 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Pittsburg Pa.

PARENTS

10-NAME OF FATHER: John Everett

11-BIRTHPLACE OF FATHER (State or country): Pa.

12-MAIDEN NAME OF MOTHER: Ella Barrett

13-BIRTHPLACE OF MOTHER (State or country): Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Frazell (husband)

(Address) 1231 Presbury St.

15 Filed NOV 12 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 9 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1917, to Nov. 9 1917, that I saw h[illegible] alive on Nov. 9, 1917, and that death occurred, on the date stated above, at 5[illegible] m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY) Nephritis

(Duration) yrs. 3 mos. ds.

(Signed), David I. Macht M. D.

Nov 12, 1917. (Address) 3618 Auchentoroly Terrace

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudenslager's | DATE OF BURIAL: Nov 14, 1917

20-UNDERTAKER: [illegible] | ADDRESS: Norwood

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 9971 — 120 — D 9971

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1152 Carroll St. WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Einwachter

(Residence in Baltimore: No. 1152 Carroll St.; ~ yrs. ~ mos. ~ ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April (Month) 28, (Day) 1849 (Year)

7 AGE: 68 yrs. 6 mos. 12 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 027

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Irving

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Baer

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Einwachter

(Address) 1152 Carroll

15.

Filed ....., 191.....

REGISTRAR

HARRY D. ANDREWS
NOV 12 1917
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 9 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1917, to Nov 9 1917, that I saw her alive on Oct 9 1917, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) 1 yrs. ..... mos. ~ ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rushmore Brain M. D.

Nov 9, 1917 (Address) 1227 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cem — DATE OF BURIAL: Nov 13, 1917

20 UNDERTAKER: W J Tuckerman — ADDRESS: Notter Pa

Spec.—8-24-14—M. & T.—2000 Bks.

D 9972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9972

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S. Bdway ST.; V WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elenora F. Hahn

(Residence in Baltimore: No. 505 S. Bdway St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept. 3 (Month) (Day) 1846 (Year)

7-AGE, 71 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Nat Brune

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lia Schwab

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Hahn

(Address) 505 S. Bdway

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Nov 9 1917, that I saw her alive on Nov 1 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. 3 mos. ....ds.

(Signed) H. Valentine M. D.

Nov 9, 1917 (Address) 1 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity — DATE OF BURIAL, Nov 13, 1917.

20-UNDERTAKER H. Sanders & Son — ADDRESS 710 Park

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 9973

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S. Collington Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret L. Haugherty-Ely

(Residence in Baltimore: No. 328 S. Collington Ave St.; 67 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Oct (Month) 9 (Day), 1850 (Year)

7-AGE, 67 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, Charles Ely

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md.

12-MAIDEN NAME OF MOTHER Catherine Bollack

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Effie Haugherty-Ely

(Address) 328 S. Collington Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1917, to Nov 9 1917, that I saw her alive on Nov 9 1917, and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

(Signed) L. D. Cannon M. D.

Nov 11, 191.7. (Address) 1711 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov 11, 1917.

20-UNDERTAKER H. Vander Sons ADDRESS 1710 Park

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

D 9974

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Eutaw Place ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Preston

(Residence in Baltimore: No. 2210 Eutaw Place St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 21 (Day), 1851 (Year)

7-AGE,	If LESS than 1 day,
66 yrs. 6 mos. 20 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, James Preston

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza A. Jenkins

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Oscar Preston

(Address) 2210 Eutaw Place

15-

Filed....., 191.....

Registrar.

NOV 12 1917 HARRY C. AS REGR Baltimore, Md. Will Clerk

CAUSE OF DEATH in plain terms, so that any one may understand it. Indefinite answers, such as "Fever," "Debility," "Old Age," "Consumption," "Dropsy," "Cancer," "Tumor," "Abscess," "Child-birth," "Accident," "Injury," "Fracture," without stating the organ affected, are not sufficient. Name the disease causing death, or, if from violence, state the means of injury. State whether accidental, suicidal or homicidal. Be particular and state fully. Do not use abbreviations or technical terms. Omission to answer any of these questions may greatly delay the issue of certificate, and in case of deaths from violence, or where the cause is not fully stated, will necessitate the holding of an inquest. Every question should be answered, and if any of the questions are deemed important, See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Nov 10 1917, that I saw h alive on Nov 8 1917, and that death occurred, on the date stated above, at 9 15 4m.

The CAUSE OF DEATH* was as follows:

Disease of Aorta & Cardiac Valves

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

11/11....., 191.7. (Address) 207 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge	Nov. 12, 1917.

20-UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9975

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Morling

(Residence in Baltimore: No. ~~Mercy Hospital~~ 1600 St Paul St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Not Known ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
61 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tin Smith
(b) General nature of industry, business, or establishment in which employed (or employer) 084

9-BIRTHPLACE, (State or Country), Not Known

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rec'd Mercy Hosp

(Address) Calvert St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1917, to Nov. 6 1917, that I saw him alive on Nov. 6 1917 and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
(Clinical Diagn.)
..... (Duration) Do not Know yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Smith M. D.

Nov 7, 191 7 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 24 ds. In the State Do not Know yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Do not Know

Former or usual residence 540 - 47th St Brooklyn N.Y.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
HOPKINS HOSPITAL	NOV 10 1917 ....., 191...
20-UNDERTAKER	ADDRESS
Commissioner Health.	
Per. Wm. E. WOODALL	

important. See instructions on back of certificate.

16287

D 9976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159

D 9976

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Flemming

(Residence in Baltimore: No. 1948 W Pratt St

St. 42 yrs. 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH. May 29, 1875
(Month) (Day) (Year)

7-AGE. 42 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Just Dealer 045
(b) General nature of industry, business, or establishment in which employed (or employer). for Himself

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Flemming

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER. Elizabeth Turner

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Flemming

(Address) 1948 W Pratt St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to E. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound in Brain Suicidal

(Duration) ..... yrs. one hour mos. ..... ds.

CONTRIBUTORY (Secondary) Manial Depression.

(Duration) ..... yrs. 5 mos. 1 ds.

(Signed) James M Fenton M. D.
(Coroner.)

Nov 11 191 7 (Address) 120 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Franklin Sq Hosp one hour

Where was disease contracted, if not at place of death? .....

1934 Frederick Ave

Former or usual residence 1948 W Pratt St

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. Nov 12, 1917

20-UNDERTAKER. George Lehmann & Bro ADDRESS 2101 Eutaw Ave

N. B. Every item of information must be given in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 9977

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 n Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Jane Proctor

(Residence in Baltimore: No. 1034 n Chapel St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Samuel Jackson

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Proctor

(Address) 1033 n Durham St

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 9 1917, to Nov 10 1917, that I saw h.. alive on Nov 9th 1917, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(Duration) ..... yrs. 8 mos. ..... ds.

(Signed) J. Edward Fenton M. D.

Nov 11 1917 (Address) 1612 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cibury

DATE OF BURIAL, Nov 13, 1917

20-UNDERTAKER John A Henderson

ADDRESS 317 Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D 9978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9978

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Centeulan ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca mills

(Residence in Baltimore: No. 518 N. Centeulane St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Col	Widow

6-DATE OF BIRTH, ... Jan (Month) ..... 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
65 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 970

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wesley Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. J. Smith

(Address)..... 518 N. Central

15-

Filed....., 191.....
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) ..... 9 (Day) ....., 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 2 191 7, to Nov 9 191 7, that I saw h W alive on Nov 8 191 , and that death occurred, on the date stated above, at 4a.m.

The CAUSE OF DEATH* was as follows:

..... Bright's Disease .....

..... (Duration)..... yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... W. C. Burns M. D.

Nov 9, 191 7 (Address)..... 2 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	Nov 12, 1917
20-UNDERTAKER	**ADDRESS**
John C Henderson	319 Carolina

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9979

CERTIFICATE OF DEATH.

28

D 9979

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 Homewood Av ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna V. Bowers

(Residence in Baltimore: No. 1040 Homewood Av St.: 19 yrs., 6 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April 5th, 1898
(Month) (Day) (Year)

7-AGE, 19 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Henry M. Bowers

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md

12-MAIDEN NAME OF MOTHER Marie Cornelius

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Henry M. Bowers

(Address) 1040 Homewood Av

15-

Filed....., 191.....
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1917, to Nov 10 1917, that I saw h Sd alive on Nov 9 1917, and that death occurred, on the date stated above, at 4 1/2 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Dr Bernard Wise M. D.

11-10, 1917. (Address) 914 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. November 13, 1917

20-UNDERTAKER Henry Woech Son

ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D 9980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Park Avenue ST.: ... WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan A. Johns

(Residence in Baltimore: No. 1124 Park Avenue St.; 77 yrs., 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, September 22nd (Month) (Day), 1840 (Year)

7-AGE, 77 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " None

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Spencer Mitchell Harris

11-BIRTHPLACE OF FATHER (State or Country), Prince Georges Md

12-MAIDEN NAME OF MOTHER Josephine Haskell

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm. C. Johns

(Address) 1127 Park Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10th (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1917, to Nov 10th 1917, that I saw h[illegible] alive on Nov. 10th 1917, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

..... (Duration)..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov. 11, 191[illegible]. (Address) 1127 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, 11 13th, 1917.

20-UNDERTAKER Henry W. Jenkins & Sons Co — ADDRESS 1 Richard & McCulloh Sts

important. See instructions on back of certificate.

NOV 12 1917 — Burial Permit Issued — Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9981 D 9981

CERTIFICATE OF DEATH.

67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 South Charles ST. 23 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. Harvey McClay

(Residence in Baltimore: No. 930 South Charles St

St.: 48 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, May (Month) 18 (Day), 1862 (Year)

7-AGE, 55 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Coleseek Lumber
(b) General nature of industry, business, or establishment in which employed (or employer).....

67

9-BIRTHPLACE, (State or Country), Augusta, Georgia

PARENTS.

10-NAME OF FATHER. Charles F. McClay

11-BIRTHPLACE OF FATHER (State or Country) Lewisburg, Pa.

12-MAIDEN NAME OF MOTHER Narcissa Williams

13-BIRTHPLACE OF MOTHER (State or Country), Eatonton, Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. M. Buchanan

(Address) 930 South Charles St

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1917, to Nov 11th 1917, that I saw him alive on November 11th 1917, and that death occurred, on the date stated above, at 2-30 m.

The CAUSE OF DEATH* was as follows:

pneumonia

(Duration) ....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary) General Paresis

(Duration) 5-6 yrs. (uncertain) mos. ....ds.

(Signed) John Rathbun Oliver M. D.

Nov. 11..., 1917 (Address) Latrobe Apartments

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Augusta Georgia — DATE OF BURIAL, 11-13-1917

20-UNDERTAKER Henry W. Jenkins Sons Co — ADDRESS Richard & McCulloh

Spec.—8-24-14—M. & T.—2000 Blks.

D 9982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 9982

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Eutaw Place St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret S. Landis

(Residence in Baltimore: No. 1601 Eutaw Place St.; 54 yrs., 3 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH. July 31, 1863 (Month) (Day) (Year)

7-AGE. 54 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John P. Schmidt

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth Joh

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary E. Landis

(Address) 1601 Eutaw Place

15-

Filed....., 191.....

Registrar.

NOV 12 1917 REGISTRAR OF VITAL STATISTICS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 11th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1917, to Nov 11th 1917, that I saw h er alive on Nov 8 1917, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast uteri

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Wm. H. Peal M. D.

Nov 11, 191 7 (Address) 205 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. ✓ ds. In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence ✓

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemy — DATE OF BURIAL. Nov 13, 191 7

20-UNDERTAKER Stewart & Mowen Co — ADDRESS 108 W. North

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 9983

REGISTERED No. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34-East-25th. Street. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jenny Lind Green.

(Residence in Baltimore: No. 34-East-25th.street. St.; 56 yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, August (Month) 26 (Day), 1861 (Year)

7-AGE, 56 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Organist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Grace M.E.Church

766 086

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Louis Muller.

11-BIRTHPLACE OF FATHER (State or Country). Penna.

12-MAIDEN NAME OF MOTHER Eudocia G. Hills.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Ellwood A. Green (husband)

(Address).....34-East-25th. Street.....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9th. 1917, to Nov 9th' 1917., that I saw her alive on Nov 9th. 1917., and that death occurred, on the date stated above, at 2.30P m.

The CAUSE OF DEATH* was as follows:

Intussusception.

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration).....yrs.....mos.....ds.

(Signed) Otto M Eisenhardt M. D.

Nov. 9, 1917. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Nov. 12/17 191...

20-UNDERTAKER Stewart & Mowen Company

ADDRESS 108W. North

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9984

CERTIFICATE OF DEATH.

D 9984

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3535 Hickory Ave. (St.; 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Wilson

(Residence in Baltimore: No. 3535 Hickory Ave. St.; — yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. (Month) 10 (Day), 1917 (Year).

7-AGE, — yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harrison Wilson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Julia Corbin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Harrison Wilson

(Address) 3535 Hickory Ave.

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 11 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1917, to Nov 11th 1917, that I saw h[illegible] alive on Nov 10th 1917, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 11 ds.

(Signed) [illegible] M. D.

Nov. 11, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Mary's Hampden	Nov. 12, 1917
20-UNDERTAKER Horace Burgee & Son	ADDRESS 3631 Falls Rd.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9985

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm F. Maisch

(Residence in Baltimore: No. 1342 N. Bond St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, December (Month) 11 (Day), 1855 (Year)

7-AGE, 62 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Drug Store

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Maisch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. W. Hurd.

(Address) 1342 N. Bond St.

15-

Filed ....., 191.....

Registrar.

NOV 12 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1917, to Nov 10 1917, that I saw h... alive on Nov 9 1917, and that death occurred, on the date stated above, at 12:03 a.m.

The CAUSE OF DEATH* was as follows:

D.
Carcinoma of Bladder
Operation (Duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. ds.

(Signed) L. W. Hurden M. D.

11-10-, 191.7 (Address) Bond Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 14 ds. In the State 62 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1342 N. Bond St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Nov 12, 1917

20-UNDERTAKER Harry A. Wiltze ADDRESS 1530 Linden Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2555 Florence St.: 13 WARD)

2-FULL NAME Matilda Morris

(Residence in Baltimore: No. 2555 Florence St.: yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October (Month) (Day) 1850 (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). (None)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Morris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Matilda Frey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 2555 Florence St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

....., 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Nov 13 17

20-UNDERTAKER Edward Ringgold ADDRESS 1463 N Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9987

CERTIFICATE OF DEATH.

151 D 9987

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Winterling

(Residence in Baltimore: No. 3404 Lombard St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) S.

6-DATE OF BIRTH. Nov 11, 1917 (Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, H. Winterling

11-BIRTHPLACE OF FATHER (State or Country) Balto Co Md

12-MAIDEN NAME OF MOTHER Anna Ebert

13-BIRTHPLACE OF MOTHER (State or Country) Balto Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Winterling

(Address) 3404 E. Lombard St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 191 7, to Nov 11 191 7, that I saw her alive on Nov 11 191 7, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: Premature birth 5½ mo.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endometritis (Puerperal)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest P. Wells M. D.

11-11-, 191 7 (Address) 21 S. Paca St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 3404 Lombard St

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cemetery DATE OF BURIAL, Nov 12, 1917

20-UNDERTAKER Zilly & Zeiler ADDRESS 403 S Mosher

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 9988

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles & Franklin ST.; 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Kenly Coady

(Residence in Baltimore: No. The Rochambeau St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, February 6, 1876
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 9 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER, Oliver Kenly

11-BIRTHPLACE OF FATHER (State or Country), Harford Co.

12-MAIDEN NAME OF MOTHER Louisa Stuart

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Charles P. Coady.....

(Address)....The Rochambeau Apartments

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Nov. 11 1917, that I saw h r alive on Nov. 10 1917, and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Uremia (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

.....(Duration)....yrs....mos....ds.

(Signed) E. R. Brettone M. D.

Nov. 11, 1917. (Address) 171 E. Pacific St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral Cemetery	Nov. 14, 1917
20-UNDERTAKER	ADDRESS
Henry B. Myers & Son	805 N. Calvert St.

important. See instructions on back of certificate.

D 9989

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

81

D 9989

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 110 n Pine St. 4 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elise Deligmon

(Residence in Baltimore: No. 110 n Pine St.; 5 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: July (Month) 12 (Day), 1829 (Year)

7 AGE: 88 yrs. 3 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): "

9 BIRTHPLACE (State or country): Alsace Germany

PARENTS

10 NAME OF FATHER: Elias Wolf

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dourtheon

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Seligman

(Address) 2378 Madeira Ave

15.

Filed NOV 12 1917, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November (Month) 10 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1917, to Nov 10 1917.

that I saw h[er] alive on Nov 9, 1917.

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY) Pulmonary Congestion

(Duration) yrs. mos. 10 ds.

(Signed) Chas F Blair M. D.

Nov 11, 1917 (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ahel Sholom Cem — DATE OF BURIAL: 11-13-1917

20 UNDERTAKER: J H Freeso Co — ADDRESS: 16 N Read Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 9990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 9990

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Register ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa May Jones

(Residence in Baltimore: No. 415 N. Register St.: 49 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	colored	Married

6-DATE OF BIRTH, ... Mar (Month) 17 (Day), 1868 (Year)

7-AGE, 49 yrs. 7 mos. 22 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Tina — Don't know last name

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John Martin

(Address)..... 415 N. Charles St

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 191 7, to Nov 8 191 7, that I saw h er alive on Nov 7 191 7, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

.....

..... Pleuro Pneumonia

..... (Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos. 2 ds.

(Signed) ..... M. D.

Nov 8, 1917, (Address) 1 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery — DATE OF BURIAL, Nov 12 191 7

20-UNDERTAKER Milton. Davis — ADDRESS 413 N. Eden

JT

D 9991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Franklin Square Hospital St.) WARD)
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Nevitt
(Residence in Baltimore: No. 331 7th St. S.E. Washington D.C. St.; ..... yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Dec 28, 1896
(Month) (Day) (Year)

7-AGE, 21 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tool Keeper 096
(b) General nature of industry, business, or establishment in which employed (or employer)..... Washington D.C. machine Shop

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Charles F Nevitt
11-BIRTHPLACE OF FATHER (State or Country) Maryland
12-MAIDEN NAME OF MOTHER Frances Dean
13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna M Horne
(Address) 331 7th St SE Wash

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture Skull in Collision with Automobile while he was on Motor Cycle (Duration) ..... yrs. ..... mos. 1/2 ds.
CONTRIBUTORY (Secondary) Hemorrhage with brain (Duration) ..... yrs. ..... mos. 1/2 ds.
(Signed) James McKenlock M. D. (Coroner.)
Nov 12 1917 (Address) 1st & Clarke

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Franklin Sq Hosp the of death.....yrs.....mos. 7/12 ds. State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? Howard St
Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL, Washington DC — DATE OF BURIAL, Nov 13, 1917
20-UNDERTAKER Robert Brooks — ADDRESS Calhoun & Wallace Sts

N. B. Every question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 9992

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 S. Curley ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fredrick Lohman

(Residence in Baltimore: No. 1022 S Curley Co. St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 7, 19.... (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... infant.

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm Lohman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Jennie Staple

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Lohman

(Address) 1022 S. Curley St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1917, to Nov 11 1917, that I saw him alive on Nov 7 1917, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

.....

.....

asphyxia

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Capillary Bronchitis

..... (Duration) ....yrs. ....mos. 12 ds.

(Signed) Dr W. Wright M. D.

Nov 11, 1917. (Address) 3048 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Nov 12, 1917

20-UNDERTAKER Philip Herrig — ADDRESS 2016 Aliceanna

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9993 ✓ 109 D 9993

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Elizabeth Hoffman

(Residence in Baltimore: No. 4521 Glendon Ave St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Dec 7, 1910
(Month) (Day) (Year)

7-AGE, 6 yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Louis C. Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Hanne E Fuld

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis C. Hoffman

(Address) 4521 Glendon Ave

15-

Filed....., 191.....
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 12 1917, that I saw her alive on Nov 12 1917, and that death occurred, on the date stated above, at 1a. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration—Interval between beginning of fatal symptoms and death) about 5 hours

(Contributory) (Secondary) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) 3 yrs. mos. ds.

(Signed) Bernard S Jacobson M. D.

11 Nov, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 4521 Glendon Ave Baltimore

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Nov 14, 1917.

20-UNDERTAKER Wm Lewis Carroll ADDRESS 108 N Potomac

Spec.—8-[illegible]14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9991 D 9992

CERTIFICATE OF DEATH.

X110

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wesley Cramer

(Residence in Baltimore: No. 1110 E. 3rd St. Highlandtown St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. (Month) 1 (Day), 1867 (Year)

7-AGE, 50 yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Asst. Police
(b) General nature of industry, business, or establishment in which employed (or employer)..... " " 061

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Casper Cramer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Tabet

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rec'd Mercy Hosp.

(Address) Chas. St.

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29 1917, to Nov. 8 1917, that I saw him alive on Nov 8 1917, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Interstitialis Cystic

Hours (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Chas. A. Bunch M. D.

Nov 8, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1110 3rd St Highlandtown

Former or usual residence 1110 3rd St Highlandtown

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	Nov. 11, 1917
20-UNDERTAKER, Chas. Crowley.	ADDRESS 25 N Fulton

important. See instructions on back of certificate.

5-2

D 9995

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 5 D 9995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 820 Hartman ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Miller

(Residence in Baltimore: No. 820 Hartman ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Mulatto

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1852 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman 833 986
(b) General nature of industry, business, or establishment in which employed (or employer): Kitchen

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac Miller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Hunter

13-BIRTHPLACE OF MOTHER (State or Country), D. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Williamson

(Address) 1903 Harlem ave

15-

Filed ....., 191.... ROBERT B. KRAUTER Registrar.

NOV 12 1917 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Morphine Poisoning

Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

....., 191.... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Nov 13, 1917

20-UNDERTAKER J. F. Walker — ADDRESS 723 W Lf

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 9996

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hardman

(Residence in Baltimore: No. 406 E Biddle St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem.	White	Married

6-DATE OF BIRTH, Sept. 12, 1881
(Month) (Day) (Year)

7-AGE, 36 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael F. Conroy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Hardman

(Address) 406 E. Biddle Street

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-25 1917, to 11-10 1917, that I saw h[illegible] alive on 11-9 1917, and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy

(Duration) yrs. 8 mos. ds.

(Signed) Dr Bernard West M. D.

11-10 1917. (Address) 914 E. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov. 13, 191.7

20-UNDERTAKER J. C. Wadsfell & Co — ADDRESS Fremont St

important. See instructions on back of certificate.

NOV 12 1917 ROBERT R. KRAUTER Burial Permit

) 9997

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

134 ✓ 9997

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE (No. 3904 Old York Road ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chalanta Robine Saffington

(Residence in Baltimore: No. 3904 Old York Road St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: April 24, 1829 (Month) (Day) (Year)

7-AGE: 88 yrs. 6 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Kent Co., Md

PARENTS

10-NAME OF FATHER: Purnell D. Smith.

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Mary Everett.

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mayo. Hall

(Address) 3904 Old York Rd

15.

NOV 12 1917 ROBERT R. KRAUTER

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 11, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1917, to Nov 11 1917, that I saw h[illegible] alive on Nov 11, 1917, and that death occurred, on the date stated above, at 3.15 ·m.

The CAUSE OF DEATH* was as follows:

Senility.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. Evans M.D.

Nov 12, 1917 (Address) 502 Franklin Ter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Nov 13, 191?

20-UNDERTAKER: H. C. Wedgwood ADDRESS: Greenmount

N. B.-Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Mary L. Baskin

D 9998

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

+ 32 D 9998

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; ✓ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lonza Baskin

(Residence in Baltimore: No. Mercy Hospital St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June 20, 1913
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
4 yrs. 4 mos. 23 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " 000

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Mary Baskin

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Glendora Byas

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Glendora Baskin

(Address) Florence S. C.

15-

Filed....., 191.....

Registrar.

NOV 12 1917 ROBERT H. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Nov. 12 1917, that I saw h[illegible] alive on Nov. 12 1917, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

1st Lobar Pneumonia

alone (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock After Labor (Duration) yrs. mos. ds.

(Signed) Edward [illegible] M. D.

Nov 12, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 14 ds. In the State ....yrs. ....mos. 14 ds.

Where was disease contracted, if not at place of death? Florence S. C.

Former or usual residence Florence S. C.

19-PLACE OF BURIAL OR REMOVAL, Florence South Carolina — DATE OF BURIAL, Nov. 12. 1917.

20-UNDERTAKER Geo A Lerby — ADDRESS Balto Bayard St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 9999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 9999

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] St.; [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sydney Henderson

(Residence in Baltimore: No. Hamilton, Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write the word.*) Single

6-DATE OF BIRTH, [illegible] (Month) ..... (Day), 1906 (Year)

7-AGE, 11 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work S B
(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, C. E. Henderson

11-BIRTHPLACE OF FATHER (State or Country) West Indies

12-MAIDEN NAME OF MOTHER Caroline Rose

13-BIRTHPLACE OF MOTHER (State or Country). West Indies

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Howard

(Address) Hereford Md.

15-

NOV 12 1917 ROBERT H. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/25 1917, to 11/11 1917, that I saw h[illegible] alive on 11/11 1917, and that death occurred, on the date stated above, at 6:15 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) [illegible] M. D.

11/11, 1917 (Address) Maryland Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Hamilton Md

19-PLACE OF BURIAL OR REMOVAL Harford Baptist Cemetery

DATE OF BURIAL, Nov. 14, 1917

20-UNDERTAKER Horace Bunce & Son

ADDRESS 363 Walbrook Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10000

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 W. Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Felix D. Barnes

(Residence in Baltimore: No. 1128 W Franklin St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, May 23, 1856 (Month) (Day) (Year)

7-AGE, 61 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Light St. Wharf

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louise Brenson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Barnes

(Address) 1128 W. Franklin

15-

Filed....., 191.....

Registrar.

NOV 12 1917 ROBERT R. KRAUTER Board of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Nov. 12 1917, that I saw h[im] alive on Nov 11 1917, and that death occurred, on the date stated above, at 5[10] a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Cerebral Hemorrhage
Chronic Interstitial Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 1½ ds.

(Signed) J. F. Hemmeter M. D.

Nov 12, 1917 (Address) 804 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Nov. 14 1917.
20-UNDERTAKER Wellemin Cook	ADDRESS 504 E North Ave.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 10001

HEALTH DEPARTMENT—CITY OF BALTIMORE

10001

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Strickland ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Fischer

(Residence in Baltimore: No. 3306 Strickland St.: 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 6, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Wm Studie

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Stuart

(Address) 3306 Strickland St

15-

Filed....., 191.....

Registrar.

NOV 12 1917 ROBERT R. KRAUTER

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 10 1917, that I saw h[illegible] alive on Nov 9 1917, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(Duration) 1 yrs. mos. ds.

(Signed) Howard Jones M. D.

Nov. 12, 1917. (Address) Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Nov 13, 1917.

20-UNDERTAKER George A Starkey — ADDRESS Light & Sutton

Spec.—5-19-13—M. & T.—500 Bks.

D10002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D10002

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 N Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine E Irwin

(Residence in Baltimore: No. 1726 N. Monroe St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 13 (Month) (Day), 1874 (Year)

7-AGE, 42 yrs. 10 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Drug Clerk
(b) General nature of industry, business, or establishment in which employed (or employer), W. H. D. Gilbert & Co Wholesale Drugs

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Irwin

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER, Mary McKernan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Annie Burtnett

(Address) 1726 N. Monroe St.

15-

Filed....., 191.....

Registrar.

NOV 12 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Nov. 12 1917, that I saw her alive on Nov. 11 1917, and that death occurred, on the date stated above, at 0a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) Chas. H. Barbert M. D.

Nov. 12 1917. (Address) 1100 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Nov. 13 1917.

20-UNDERTAKER Robb-T. Turner

ADDRESS 1742 N. Broadway

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10003

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Landau

(Residence in Baltimore: No. 1114 S. Kenwood Ave St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec. 17, (Month) (Day) 1875 (Year)

7-AGE, 41 yrs. 10 mos. 22 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. General Labor
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Isaac J. Landau

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Laura V. Pittchard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. M. Landau

(Address) 2713 Elliott st.

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 10, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 28 1917, to Nov. 10, 1917, that I saw him alive on Nov. 10, 1917, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decomp.

(Duration) yrs. mos. 13 ds.

(Signed) J. Edw. Nottes M. D.

11/10/17 191... (Address) St. Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State life yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1114 S. Kenwood Ave.

19-PLACE OF BURIAL OR REMOVAL, Baltimore County. DATE OF BURIAL, Nov. 13.., 191.7.

20-UNDERTAKER Robt. T. Turner ADDRESS 1472 N. Broadway

D10001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating off Pier 9 Locust Point.

CITY OF BALTIMORE (No. ..... St.: 24 WARD)

REGISTERED No. C 166 10001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. Johnson. Reginald Cyril Johnson.

(Residence in Baltimore: No. England. 75 Chester Road West Hartlepool St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE, ~~19.~~ 18 yrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Apprentice boy on Steamship
(b) General nature of industry, business, or establishment in which employed (or employer): Kerry Range.

9-BIRTHPLACE, (State or Country) West Hartlepool England.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

Records lost when ship was destroyed by fire.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Capt. Robert Howard.
(Informant) S.S. Kerry Range.
(Address) England.

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30th. 1917.
Body found November 11th. 1917 .....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned about the body and probably Drowned at Pier #9 Locust Point fire.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto A. Reinhardt (Coroner) M. D.
Nov. 12, 1917 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence ..... England. .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetary	Nov 14, 1917
20-UNDERTAKER Christian Miller	ADDRESS 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10005

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

+166 D10005

1-PLACE OF DEATH: Found floating off
CITY OF BALTIMORE (No. Pier 4 Locust Point. St.: 24 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Albert Bask. Algot Baskr

(Residence in Baltimore: No. England. 10 Campbell St Liverpool St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	~~Married.~~ Unknown

6-DATE OF BIRTH, Do not know. (Month), (Day) 1 (Year)

7-AGE, ~~about.~~ ~~30~~ 27 yrs ....yrs. ....mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Sailor on Steamship (b) General nature of industry, business, or establishment in which employed (or employer): Kerry Range. 086

9-BIRTHPLACE, (State or Country), Sweden.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

Records lost when ship was destroyed by fire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Captain Robert Howard.
(Informant) S.S. Kerry Range.
(Address) England.

15-
Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30th. 1917.
Body found November 11th. 1917, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to hi* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned about the body and probably drowned at Pier #4 Locust Point fire.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ~~Otto~~ (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
Nov. 12th. 1917 (Coroner)
(Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence England.

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetary | DATE OF BURIAL, Nov 13 ....., 1917

20-UNDERTAKER Christian Miller | ADDRESS 2334 Kelly Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating off
CITY OF BALTIMORE (No. Pier 9 Locust Point. ST.: 24 WARD) + 166

REGISTERED NO. C D10006

2-FULL NAME Eustace Bromley. Eustace A Bromley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. England. 13 Hamberley Road Exeter St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE, ~~about 40~~ 43 yrs ....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chief Gunner on Steamship
(b) General nature of industry, business, or establishment in which employed (or employer)..... Kerry Range.

9-BIRTHPLACE, (State or Country), England. London

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

Records lost when ship was destroyed by fire.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)..... Captain Robert Howard. S.S. Kerry Range.
(Address)..... England.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30th. 1917. Body found November 12th. 1917, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burned about the body and probably drowned at Pier #9 Locust Point fire.

..... (Duration).....yrs.....mos.....ds.
CONTRIBUTORY (Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.
Nov. 12th, 1917. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence England.

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery. DATE OF BURIAL, Nov 13, 1917.

20-UNDERTAKER Christian Miller ADDRESS 2834 Frederick st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10007

CERTIFICATE OF DEATH.

29 ✓

D10007

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 500 N. Lakewood Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm B. Graham

(Residence in Baltimore: No. 500 N. Lakewood Ave St.; 36 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. June 8 (Month) 1881 (Day) 1881 (Year)

7-AGE. 36 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foreman 086
(b) General nature of industry, business, or establishment in which employed (or employer) General Contracting

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. C. C. Graham

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary L Davis

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Graham

(Address) 500 N. Lakewood Ave

15-

NOV 12 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11 (Month) 17 (Day) , 191... (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov 11 1917, that I saw h[illegible] alive on Nov 10- 191..., and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Phthisis Florida

Tuberculosis (Primary)

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Geo C. Wades M. D.

Nov 12, 191... (Address) 1436 E. 3rd way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Nov 13, 191..
20-UNDERTAKER Christian Miller	ADDRESS 2330 Jefferson St

important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10008

CERTIFICATE OF DEATH

64 V D10008

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2701 Pennsylvania Av ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Maria Hebbel

(Residence in Baltimore: No. 2701 Penna. Av St.) 51 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec. (Month) 17th (Day), 1845 (Year)

7-AGE: 71 yrs. 10 mos. 23 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

X

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: not known

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. R. Hebbel

(Address) 2701 Penna Av.

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 11th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1917, to, Nov 11 1917, that I saw h.. alive on Nov 11 1917, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Paralysis

(Duration) ..... yrs 5 mos. ..... ds.

Contributory (SECONDARY) Hard. of arteries

(Duration) ..... yrs ..... mos. 7 ds.

(Signed) C. L. Smith M. D.

Nov 11, 1917 [Address] 1605 N Monroe

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore

DATE OF BURIAL: Nov 14 1917

20-UNDERTAKER: Geo N. Little

ADDRESS: 531 N Fremont Av

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact abbreviations of words are allowed.
TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10009

CERTIFICATE OF DEATH.

113 D10009

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Madison ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Freeman

(Residence in Baltimore: No. 2020 Madison Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Aug (Month) 26th (Day), 1860 (Year)

7-AGE, 57 yrs. 2 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cigar 043
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Mfg.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Simon Freeman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henriette Hartman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Freeman

(Address) 2020 Madison Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 11th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Nov. 10th 1917, that I saw h.. alive on Nov. 10th 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY, (Secondary) Hypertrophic Liver c myocarditis + nephritis

..... (Duration) 1½ yrs. ..... mos. ..... ds.

(Signed) Maurice L. Abrams M. D.

Nov. 11th, 1917. (Address) 1634 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	Nov 13, 1917
20-UNDERTAKER	ADDRESS
Paul Goodwin	118 Park Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 716 Edmondson Ave St., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine T. Sweeney

(Residence in Baltimore: No. 716 Edmondson Ave St.; 44 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Jan 2 ....., 1865
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. 10 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... Wife

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, James Finnigan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Fagan

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jas. H. Sweeney

(Address)..... 716 Edmondson Ave

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 10 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1917, to Nov 10 1917, that I saw h[er] alive on Nov 9 1917, and that death occurred, on the date stated above, at 9 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinosis Abdominalis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) 3/4 yrs.....mos.....ds.

(Signed)..... J. F. Kirby .....M. D.

Nov 11, 1917 (Address) 1106 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	11/13, 1917

20-UNDERTAKER	ADDRESS
Chas. E. Evans & Son	118 North Royal Ave

NOV 12 1917 ROBERT H. KRAUTER BURIAL PERMIT CLERK

Spec.—8-24-14—M. & T.—2000 Bks.

D1001.1 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 92 D1001.1

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 Oslend ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fisher

(Residence in Baltimore: No. 853 Oslend St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, ... 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Steamer ood
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Do not know Md

PARENTS.

10-NAME OF FATHER. Do not know

11-BIRTHPLACE OF FATHER (State or Country), Do not know

12-MAIDEN NAME OF MOTHER Do not know

13-BIRTHPLACE OF MOTHER (State or Country), Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Fisher

(Address) 853 Oslend

15-

Filed ....., 191.....

NOV 13 1917 HARRY C. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1917, to Nov 10 1917, that I saw her alive on Nov 9 1917, and that death occurred, on the date stated above, at 10 40 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. Morley Hoffman M. D.

Nov 11, 1917. (Address) 7 W Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 11-13 ....., 191...

20-UNDERTAKER John H Soadin — ADDRESS 142 W Pratt St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

10012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126

D10012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Cordrey

(Residence in Baltimore: No. 1550 Argyle Ave St.; ... yrs.. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown 1 ..... (Month) (Day) (Year)

7-AGE, 73 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John H Cordrey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Adline White

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Bell

(Address) 1550 Argyle Ave

15-

Filed ....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Nov 10 1917, that I saw h... alive on Nov 10 1917, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ... yrs. 1 mos. ... ds.

(Signed) Edw H Cordrey M. D.

Nov 11, 1917 (Address) 1550 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 28 ds. In the State 74 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1550 Argyle Ave

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 13, 1917

20-UNDERTAKER Samuel Handley — ADDRESS 518 W Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10013

19 D10013

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 617 Greenmount Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Dickinson

(Residence in Baltimore: No. 617 Greenmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1857 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 833
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grand Daughter

(Address) 617 Green Mount Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
of Heart about 4 years
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

....., 191.. (Address) 819 E Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 7 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov. 14, 1917

20-UNDERTAKER Mrs R A Elliott — ADDRESS 504 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D16011 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D16011

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 N. Fulton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rowena Berryman Wood.

(Residence in Baltimore: No. 1521 North Fulton Ave. St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, December 27, (Month) (Day) 1845 (Year)

7-AGE, 71 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph Berryman

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Sarah Rowell

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena W. Taylor

(Address) 1521 Fulton Ave

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 12th. (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27th. 1917, to Nov. 11th. 1917, that I saw her alive on Nov. 11th. 1917, and that death occurred, on the date stated above, at 12.15 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Fractured Hip (Over)

(Duration) yrs. 3 1/2 mos. ds.

(Signed) O. H. Durall M. D.

Nov. 12 1917 (Address) 1817 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Nov. 14. 1917

20-UNDERTAKER Wm. Cook ADDRESS 502 E North

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D16015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D16015

CERTIFICATE OF DEATH.

64 ✓

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 W. Balto ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Gamble

(Residence in Baltimore: No. 920 W. Balto St. St.: Lefferman ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. Jan (Month) 13 (Day), 1856 (Year)

7-AGE. 61 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country). Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Eugene Gamble

(Address). 920 W. Balto

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Oct 2~~ Nov (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1914, to Nov 11 1917, that I saw h-er alive on Nov 11 1917, and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(Recurrent)

(Duration) 3 yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis, over

(Duration) over 3 yrs. mos. ds.

(Signed) Henry E Otte M. D.

Nov 12, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dulaney Cemetery	Nov 14, 1917
20-UNDERTAKER Geo F Smith	ADDRESS 1000 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D16016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D16016

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Dill

(Residence in Baltimore: No. 609 N. Calvert St. St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Single

6-DATE OF BIRTH, Aug. (Month) 4th (Day), 1848 (Year)

7-AGE,	If LESS than 1 day,
69 yrs. 3 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Messenger
(b) General nature of industry, business, or establishment in which employed (or employer)..... Penn. R.R. 073

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9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Dill.

11-BIRTHPLACE OF FATHER (State or Country), Born Baltimore Md

12-MAIDEN NAME OF MOTHER, Margaret E. Kraemer

13-BIRTHPLACE OF MOTHER (State or Country), York Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. F. Sachs.....

(Address) Gettysburg Pa

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11 1917, to Nov. 13 1917, that I saw h[illegible] alive on Nov. 12 1917, and that death occurred, on the date stated above, at 2.00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) Edward [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State [illegible] yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 609 N Calvert St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Gettysburg Pa	Nov 17, 191[illegible]

20-UNDERTAKER Henry W. Jenkins Sons Co ADDRESS [illegible] Orchard Sts.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10017 D10017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 N. Lee St.; 22 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Polockoff

(Residence in Baltimore: No. 654 N. Lee St.; 24 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, Unknown (Month) (Day), 1857 (Year)

7-AGE, 58 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 12 1917, that I saw h[illegible] alive on Nov 7 1917, and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

a Chronic Valvular Heart Disease (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) — yrs. — mos. — ds.

(Signed) Henry Byrd Kinsley M. D.

Nov 14, 1917. (Address) 1610 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel — DATE OF BURIAL, 11/13, 1917.

20-UNDERTAKER Josh Lewis — ADDRESS 1411 E Balto

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D16018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

D16018

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Oxford ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Thomas

(Residence in Baltimore: No. 529 Oxford St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colud	Widower

6-DATE OF BIRTH, Dont Known (Month), (Day) 1877 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 046

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dont Known

13-BIRTHPLACE OF MOTHER (State or Country), Dont Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Thomas

(Address) 529 Oxford St

15-

Filed ....., 191.....

Registrar.

NOV 13 1917 HARRY C. ANDREWS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1917, to Nov 10 1917, that I saw him alive on Nov 8 1917, and that death occurred, on the date stated above, at 7 7 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. M. Coard M. D.

11/11, 1917. (Address) 2005 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn	Nov 13, 1917
20-UNDERTAKER John H Owens	ADDRESS 5-39 Dolphin St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10019 50 ✓ D10019

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sallie Schreiber

(Residence in Baltimore: No. 2229 Madison Ave St.; lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Isaac Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Matilda Lauffheim

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S Mitchell
Stanfield

(Address)

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1917, to Nov 12 1917, that I saw her alive on Nov 12 1917, and that death occurred, on the date stated above, at 8 40 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 1 ds.

(Signed) Bernard D Jacobson M. D.

Nov 12, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2229 Madison Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Nov 14, 1917

20-UNDERTAKER David Sandheim — ADDRESS 1108 Lombard

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10020 D10020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Fineles Ave Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Penn

(Residence in Baltimore: No. In Hospital St.; — yrs. — mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct (Month) 13 (Day), 1854 (Year)

7-AGE, 63 yrs. — mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work florist
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Balto County, Md.

PARENTS.

10-NAME OF FATHER, Wm Penn

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary A Richard

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Harry Penn

(Address) Glyndon Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1917, to Nov. 12 1917, that I saw h.. alive on Nov. 12 1917, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Microscopic Exam.

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid

(Duration) ? yrs. — mos. — ds.

(Signed) F. J. Roberts M. D.

12-12-, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 5 ds. In the State 63 yrs. — mos. 30 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Glyndon, Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Derry Hall Cemetery	Nov 13, 1917

20-UNDERTAKER Balto & Md ADDRESS Baltimore Md

J. F. Ecire

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10021

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1806 N. Mount St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margt. Sturgis

(Residence in Baltimore: No. 1806 N. Mount St.; Yrs. 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH March 10, 1914
(Month) (Day) (Year)

7-AGE. 3 yrs. 8 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Carroll C. Sturgis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Helen Corbin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Father

(Address) 1806 N. Mount St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acadmal Pneumonia
Duration 1 wk yrs. mos. ds.
CONTRIBUTORY (Secondary) Contusions
Duration yrs. mos. ds.

(Signed) J. McAllister M. D.
(Coroner.)
Nov. 13, 1917, (Address) 1918 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Nov 14, 1917

20-UNDERTAKER W. M. Gaulbrecht — ADDRESS 1624 Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Alec Jachelski

D10022

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

D10022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alec Jachelski

(Residence in Baltimore: No. 1000 Kenwood Ave St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	married

6-DATE OF BIRTH, November 20, 1880
(Month) (Day) (Year)

7-AGE, 36 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Jachelski

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Chachuk

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1, 1917, to Nov. 11 1917, that I saw h m alive on November 11 1917, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. 7 ds.

(Signed) A. H. Blanford M. D.

Nov. 11, 191.. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 24 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1000 Kenwood Ave

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 14, 1917.

20-UNDERTAKER W. F. Sadowski ADDRESS 905 S. Ann

important. See instructions on back of certificate.

NOV 13 1917 ROBERT M. GRAUER BUREAU OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10023

CERTIFICATE OF DEATH.

91

D10023

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Madison St., ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Celia Wilson

(Residence in Baltimore: No. 1528 Bunt St. St.; X yrs., 11 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	a c	single

6-DATE OF BIRTH, Jan. 22, 1917.
(Month) (Day) (Year)

7-AGE, X yrs. 11 mos. X ds. If LESS than 1 day, X hrs. or X min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... X .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... X .....

9-BIRTHPLACE, (State or Country).
1528 Bunt St.

PARENTS.

10-NAME OF FATHER, James Wilson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Miss Celia Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-
Filed Nov. 12 1917 5623
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21st, 1917, to Nov 11 1917, that I saw h[illegible] alive on Nov 10 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
Primary
(Duration) X yrs. X mos. 28 ds.

CONTRIBUTORY (Secondary) X
(Duration) ? yrs. ? mos. ? ds.

(Signed) Dr. Geo. L. Hall M. D.
Nov 12 1917. (Address) 1628 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death X yrs. X mos. X ds. In the State X yrs. 11 mos. X ds.
Where was disease contracted, if not at place of death? X
Former or usual residence X

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

Commissioner Health.

NOV 13 1917 JOHNS HOPKINS HOSPITAL

important. See instructions on back of certificate.

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HEALTH DEPARTMENT—CITY OF BALTIMORE

D10021

CERTIFICATE OF DEATH.

156

D10021

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.) 10 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Jamieson.

(Residence in Baltimore: No. 1017 Centre ave. St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, June 15, 1850 (Month) (Day) (Year)

7-AGE, 67 yrs. 9 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 067
(b) General nature of industry, business, or establishment in which employed (or employer)..... Policeman

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Andrew Jamieson

11-BIRTHPLACE OF FATHER (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER Maggie McGee

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Proctor

(Address) 1017 Centre

15-

NOV 13 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. Emerson M. D.
(Coroner.)

Nov 12 1917. (Address) 11 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Nov. 13, 1917

20-UNDERTAKER A. Roede & Son ADDRESS 1301 E. Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D10025

CERTIFICATE OF DEATH.

78 ✓ D10025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Kenwood Av St.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Walter Slayton

(Residence in Baltimore: No. 217 N. Kenwood Av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 21, 1867
(Month) (Day) (Year)

7-AGE, 47 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Henry C. Slayton

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Anna Riley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine C. Slayton

(Address) 217 N. Kenwood Ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from November 9 1917, to November 11 1917, that I saw h[illegible] alive on November 9 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ....yrs. ....mos. 1 day

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ....mos. ....ds.

(Signed) John G. Clunn M. D.

Nov. 14, 191.7 (Address) Fairmount & Pine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Nov. 15, 191.7

20-UNDERTAKER Elliott E. Fuller — ADDRESS 321 N Bradway

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Edward Hume.

D10026

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 14 6 ✓ D10026

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Hume.

(Residence in Baltimore: No. 1 month St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, November 5, 1873
(Month) (Day) (Year)

7-AGE, 43 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Station Agent
(b) General nature of industry, business, or establishment in which employed (or employer): 073

550

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Herman Hume

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Caroline McMillan

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

NOV 13 1917 ROBERT R. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 13 191, to Nov. 13 1917, that I saw h[illegible] alive on November 13 1917, and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon Sigmoid

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(Duration) 1 yrs. mos. ds.

(Signed) W E Lamb M. D.

Nov. 13, 191.. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Richmond W. Va.

19-PLACE OF BURIAL OR REMOVAL, Richmond Va — DATE OF BURIAL, Nov 16, 191..

20-UNDERTAKER Robert E Fuller — ADDRESS 221 N Broadway

important. See instructions on back of certificate.

D10027

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 ✓ D10027

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2758 Tivoly St.; 9 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Dahl

(Residence in Baltimore: No. 2758 Tivoly St St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Oct 19 (Month) (Day), 1875 (Year)

7-AGE: 42 yrs. — mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

539

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Henry Dahl

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Marie Melton

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Marie Dahl

(Address) 2758 Tivoly Ave.

15.

Filed ....., 191.....

REGISTRAR

NOV 13 1917 SCHEER & KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 11th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1917, to, Nov 11th, 1917, that I saw h.. alive on Nov 11th, 1917, and that death occurred, on the date stated above, at 11, 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Endocarditis

(Duration) unknown yrs. mos. ds

Contributory (SECONDARY) Cardiac Hypertrophy

(Duration) unknown yrs. mos. ds.

(Signed) J. Bennie Beall M. D.

Nov 12, 1917. (Address) 2946 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 13, 1917

20-UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

D10028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10028

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH St. Vincents Inf. Asylum. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis E. Hoover.

(Residence in Baltimore: No. 1401 Division St.; ....yrs., 2 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col'd.	Single

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, Stillborn ....yrs. 6 mos. .....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Ellicot City Found in ~~Patapsco R.~~

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Rowlett

(Address) 1219 Madison Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1917, to Nov 12, 1917, that I saw her alive on Nov 12 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

.....

.....

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Leonard M. C. Corkran M. D.

....., 191... (Address) 111 E Hoffman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. 2 mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cemetery	Nov. 14, 1917.
20-UNDERTAKER W. W. Routson	ADDRESS 230 N. Green

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10029 41 D10029

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital; Fall WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary E. Adler

(Residence in Baltimore: No. 914 McCulloh St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1.....
(Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sewing.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic .....

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Gertrude .....

(Address) 1 Balto. Md. .....

15-

Filed....., 191.....
Registrar.

NOV 13 1917 ROBERT B. KRAUTER

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1917, to Nov. 12 1917, that I saw h[illegible] alive on Nov. 12 1917, and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid.

Pleural ..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia.

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) B. M. Lafferty M. D.

Nov. 13 1917 (Address) Md General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 21 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 914 McCulloh St.

19-PLACE OF BURIAL OR REMOVAL, Lake Shore Md — DATE OF BURIAL, Nov. 17., 1917.

20-UNDERTAKER Elliott & Fuller — ADDRESS 221 N Bradley

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D16030

CERTIFICATE OF DEATH.

81 ✓ D16030

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2048 Eastern Ave ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Garrett

(Residence in Baltimore: No. 2048 Eastern Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Aug 14, 1837.
(Month) (Day) (Year)

7-AGE, 80 yrs. 2 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at Home

000 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs David Gerkes

(Address) 2048 Eastern Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2nd 1917, to Nov 11th 1917, that I saw h.. alive on Nov 11th 1917, and that death occurred, on the date stated above, at 11:20 p m.

The CAUSE OF DEATH* was as follows:

.....

..... Senility

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremic Poisoning - Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) Albert Miller M. D.

11/13/17, 191.7. (Address) 2737 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Nov 14..., 191.7.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern Ave

Important. See instructions on back of certificate.

NOV 13 1917 GEORGE B. TAGERT Registrar of Vital Statistics

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10031 D10031

CERTIFICATE OF DEATH

105

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. 1911 N. Munroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Krause

(Residence in Baltimore: No. 1911 N. Munroe St St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug (Month) 4 (Day), 1888 (Year)

7-AGE: 29 yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

177 109

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: John H. Krause

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marguerite Krause

(Address) 1911 N. Munroe St

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1917, to, Nov 11 1917, that I saw h.m alive on Nov 11 1917, and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ..... yrs ..... mos. 10 ds.

Contributory (SECONDARY) Exhaustion

..... (Duration) ..... yrs ..... mos. 12 hrs

(Signed), Chas A. Bulent M. D.

Nov. 12, 1917 [Address] 1100 W. Lafayette Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Nov 14, 1917

20-UNDERTAKER: Fred A Krause

ADDRESS: 703 S Howard St

CAUSE OF DEATH must be plainly written, and the information required in every item is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D10032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Monroe ST.; 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Emma Laura Frederick

(Residence in Baltimore: No. 913 Monroe St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 4 (Day), 1849 (Year)

7-AGE, 68 yrs. 11 mos. 9 ds.

If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Christopher Frederick

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Volkmar

13-BIRTHPLACE OF MOTHER (State or Country). Hessian Dandadl

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo C Shannon

(Address) 700 Fulton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 3 1917, to Nov 13 1917, that I saw h[illegible] alive on Nov 11 1917, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration), yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Fibroid Tumor (Uterine)

(Duration) 7 yrs. mos. ds.

(Signed) Geo C Shannon M. D.

11/13, 1917 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetary — DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER Mrs C Rohde Asst — ADDRESS 720 Pa Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10033 D10033

CERTIFICATE OF DEATH.

REGISTERED No. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirm. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florian Carrol Wilkins

(Residence in Baltimore: No. 302 E. 24th St., St.; 11 yrs., 3 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 31, 1906 (Month) (Day) (Year)

7-AGE, 11 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, James N. Wilkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Flora E. Mantz

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James N. Wilkins

(Address) 302 E. 24th St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1917, to Nov. 12 1917, that I saw h[illegible] alive on Nov. 11 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Intussusception)

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition + Myocardial Degeneration

(Duration) ....yrs. 1 mos. 20 ds.

(Signed) [illegible] M. D.

Nov. 14, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. 20 ds. In the State 11 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 302 E. 24th St., Cit.

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Nov. 15, 1917.

20-UNDERTAKER Wm A Rohdenburg

ADDRESS 720 Park Ave

important. See instructions on back of certificate.

D10034 HEALTH DEPARTMENT—CITY OF BALTIMORE D10034

CERTIFICATE OF DEATH. 169

1-PLACE OF DEATH Found floating off Balto. Yacht Club. REGISTERED No. C

CITY OF BALTIMORE (No. Spring Gardens. St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Doane Rayburn.

(Residence in Baltimore: No. Kansas City, Mo. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE, about 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 1st. class Seaman U.S. Navy. Gunner on
(b) General nature of industry, business, or establishment in which employed (or employer) S.S. Alamance.

9-BIRTHPLACE, (State or Country), Kansas City. Mo.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Ida Rayburn 1854 7th. St. Kansas City

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Dr. Otto M. Reinhardt
(Informant)
Coroner.
(Address)

15- 3.
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing Oct, 30th. 1917. Body found November 10th. 1917. ....., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Drowning.
probably accidental.
(Duration) .....yrs.....mos.....ds.
CONTRIBUTORY (Secondary)
..... (Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
Nov, 16, 1917 (Coroner)
....., 191... (Address) 1617 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence Kansas City. Mo.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Kansas City Kansas	Nov 16 1917
20-UNDERTAKER	ADDRESS
H. W. Meaverson	805 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 ✓ D10031

1-PLACE OF DEATH — CITY OF BALTIMORE (No. Found floating off Balto. Yacht Club Spring Gardens. ST.: 2-3 WARD) — REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME — Supposed to be E. D. Rayburn.

(Residence in Baltimore: No. Unknown. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White.	Unknown.

6-DATE OF BIRTH. Do not know. ....., 1 ..... (Month) (Day) (Year)

7-AGE. about 35 .....yrs.....mos.....ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Unknown. (b) General nature of industry, business, or establishment in which employed (or employer). 463 081

9-BIRTHPLACE, (State or Country). Unknown.

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto M. Reinhardt. M. D.

(Address) Coroner.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Body found November 10th. 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

probably accidental.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.

Nov, 12, 1917. (Coroner)

..... 191... (Address) 1617 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. [illegible] DATE OF BURIAL, [illegible], 191[illegible]

20-UNDERTAKER [illegible] ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

D16035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D16035

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 Chestnut Ave. St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Chas. & Rosa B. Roller

(Residence in Baltimore: No. 3406 Chestnut Ave. St.; yrs., mos. ds.) 5 hrs.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male.	white	Infant.

6-DATE OF BIRTH, Nov. 13. 1917.
(Month) (Day) (Year)

7-AGE. ...yrs. ...mos. ...ds. If LESS than 1 day, 5 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles R. Roller.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rosa B Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles R. Roller

(Address) 3406 Chestnut Ave

15-

NOV 13 1917 ROBERT B. KRAUTER

Filed ..., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13-6 AM 1917, to Nov 13-12 AM 1917, that I saw him alive on Nov 13 1917, and that death occurred, on the date stated above, at 12 55 m.

The CAUSE OF DEATH* was as follows:

Lack of development.
(Premature birth)
Premature Retention
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Immature gestation
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. Millard M. D.

Nov 13, 1917. (Address) 5 E Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Pleasant Cemetery

DATE OF BURIAL, Nov 15, 1917

20-UNDERTAKER Dunnott & Son

ADDRESS 567 Dunnott

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10036 X 120 D10036

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp St. Ward 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm L. Raymore

(Residence in Baltimore: No. In Hospital St.; ...yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 13, 1867.
(Month) (Day) (Year)

7-AGE, 50 yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Actor
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Chester - Pa.

PARENTS.

10-NAME OF FATHER, Thomas Keene

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Elizabeth Flynn

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Raymore

(Address) New Brunswick N J

15-

Filed ..., 191...
Registrar.

NOV 13 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov. 13 1917, that I saw him alive on Nov 13 1917, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (7)

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia Acidosis

(Duration) ...yrs. ...mos. 1 ds.

(Signed) ... M. D.

Nov 13, 1917 (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence New Brunswick - N. J.

19-PLACE OF BURIAL OR REMOVAL New Brunswick

DATE OF BURIAL, Nov. 14 1917

20-UNDERTAKER William Cook

ADDRESS 502 6 Watt

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

D10037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10037

CERTIFICATE OF DEATH.

69 ✓

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Columbia Ave St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Harvey

(Residence in Baltimore: No. 1125 Columbia Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 9 (Month) (Day), 1886 (Year)

7-AGE, 31 yrs. 1 mos. 4 ds.

If LESS than 1 day. ....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, John H. Harvey

11-BIRTHPLACE OF FATHER (State or Country), Balt md

12-MAIDEN NAME OF MOTHER Sophia Rollman

13-BIRTHPLACE OF MOTHER (State or Country), Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Harvey

(Address) 1125 Columbia Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191 , to Nov 13 191 , that I saw h alive on Nov 13 191 , and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY. (Secondary) Convulsions not Puerperal

(Duration) yrs. mos. 15 ds.

(Signed) Lyttleton Blair M. D.

Nov 13, 1917 (Address) 1211 N. Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER Geo Leinbrecht & Son

ADDRESS 647 N. Bath St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10038

CERTIFICATE OF DEATH.

91 D10038

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 N Mulberry ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Crotty

(Residence in Baltimore: No. 1505 N Mulberry St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. Aug 1 (Month), 1833 (Day) (Year)

7-AGE. 84 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 016
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary E. Crotty

(Address) 1505 N Mulberry St

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 12 1917, that I saw h[illegible] alive on Nov 12 1917, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cystitis Chronic.

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia.

(Duration) yrs. mos. 4 ds.

(Signed) E. Donoghue M. D.

....., 191... (Address) 424 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Nov 15, 191.

20-UNDERTAKER Joseph B Cook ADDRESS 1003 W Balto St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D16039

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D16039

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Fleet St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kwasnik

(Residence in Baltimore: No. 2412 Fleet St St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 10 (Day), 1868 (Year)

7-AGE, 49 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Packing Industry 043

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Kwasnik

(Address) 2412 Fleet St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11 (Month) (Day), 1917 (Year)

17) I HEREBY CERTIFY, That I attended deceased from Nov. 7 1917, to Nov. 11 1917, that I saw h[illegible] alive on Nov. 11 1917, and that death occurred, on the date stated above, at 11 05 m.

The CAUSE OF DEATH* was as follows: p

Lobar Pneumonia (Double)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

(Signed) Chas A Mues M. D.

11/12/17, 191... (Address) 408 S Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Nov. 14, 1917

20-UNDERTAKER William Fiaschetti ADDRESS 16 N Eastern Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10040 92 ✓ D10040

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 S Chapel. ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph S Kwurut

(Residence in Baltimore: No. 518 S. Chapel. St. St.; 1 yrs., 2 mos. 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 17 (Day), 1916 (Year)

7-AGE, 1 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): Infants

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Mikolaj Skwarut

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Annie Wolak

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mikolaj Skwarut

(Address) 518 S. Chapel St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1917, to Nov 12 1917, that I saw h[illegible] alive on Nov 12 1917, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

.....Infantile Pneumonia.....

..... (Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure

..... (Duration).....yrs.....mos. 3 ds.

(Signed) Wm. D. Stubbs M. D.

Nov 13 1917 (Address) 1612 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov 14, 1917

20-UNDERTAKER, William Gialkowski — ADDRESS 618 Eastern Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10041 D10041

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 N. Germain St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Schellenberger

(Residence in Baltimore: No. 647 N. Germain St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known, (Month) 1 (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House 037
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Schellenberger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Michael K. Schellenberger

(Address) 647 N. Germain St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 191, to Nov 12 191, that I saw her alive on Nov 12 191, and that death occurred, on the date stated above, at 2:50 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardiac Disease

Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) yrs. 6 mos. ds.

(Signed) W. Hammond Jr. M. D.

Nov 13, 191 (Address) 835 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, Nov 15, 191 7

20-UNDERTAKER Henry Horck Son ADDRESS 1301 E Eager St

NOV 14 1917 HARRY C. BYERS BUREAU OF VITAL STATISTICS

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 ✓

D10042

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Kelly

(Residence in Baltimore: No. 717 E. Chase St St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Not Known, ... (Month) ..... (Day), 1 ..... (Year)

7-AGE,	If LESS than 1 day,
50 yrs. — mos. — ds.	....hrs. or....min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Letter carrier
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John F. Kiely

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Toner

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary J. Kiely

(Address) 715 E Chase St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 1917, to Nov 13 1917, that I saw him alive on Nov. 12 1917, and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) ....yrs. 1 mos. 1 ds.

(Signed) Edward Dennett M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 50 yrs ....mos. ....ds.

Where was disease contracted, if not at place of death? At 717 E. Chase

Former or usual residence " " "

19-PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL, November 16, 1917

20-UNDERTAKER Henry Horck Son — ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Vine ST.: 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Coleman

(Residence in Baltimore: No. 807 Vine St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	widow

6-DATE OF BIRTH, Dec (Month) 5 (Day), 1882 (Year)

7-AGE, 34 yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Coleman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Curry

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm Coleman

(Address) 807 Vine

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1917, to Nov 12 1917, that I saw h er alive on Nov 11 1917, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Thurlow Tood M. D.

Nov 13 191 7. (Address) 729 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn

DATE OF BURIAL, Nov 14, 1917

20-UNDERTAKER John H Owens

ADDRESS 538 Lafayette

NOV 14 1917

important. See instructions on back of certificate.

D10041

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 ✓

D10041

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 632 Greenmount ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almo Hill

(Residence in Baltimore: No. 632 Greenmount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	Col	Single

6-DATE OF BIRTH, Oct. (Month) 1 (Day) 1917 (Year)

7-AGE, ...yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. Green

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Viola Hill

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 632 Greenmount Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Cold & Whoop

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 13, 1917 (Address) 819 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds. None

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Nov. 14, 191.

20-UNDERTAKER Samuel Everson ADDRESS 716 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10045

CERTIFICATE OF DEATH.

6 L ✓

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 E. Mt. Vernon Place. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Barbara Fawcett White.

(Residence in Baltimore: No. 17 E. Mt. Vernon Place. St.; about 35 years ...)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, July 25, 1827.
(Month) (Day) (Year)

7-AGE, 90 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Robt Garrett

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Elizabeth Stouffer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Robt Garrett

(Address)..... Roland Park Balto Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8th 1917, to Nov. 13th 1917, that I saw h[illegible] alive on November 12 1917, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wm F. Ladenburg M. D.

Nov. 14th, 1917. (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, 11-15-1917.

20-UNDERTAKER Henry W. Jenkins & Sons Co — ADDRESS Orchard & Mc Culloh

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10046 ✓ D10046

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 Greenmount Ave. St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Graham Fox

(Residence in Baltimore: No. 2727 Greenmount Ave. St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Jan. 12, 1835 ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 82 yrs. 10 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country),
Boston, Mass

PARENTS.

10-NAME OF FATHER, William MacMullen

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Elizabeth Magee

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Miss Nellie Gordon .....

(Address) 2721 Greenmount Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 13 ....., 1917..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11th 1917, to Nov 13 1917, that I saw h[illegible] alive on Nov 12 1917, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

.....
Cerebral Hemorrhage
..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Amy G. Pillsbury M. D.
Nov. 13, 1917. (Address) 2801 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Johns Comty, Woodly	11/15, 1917
20-UNDERTAKER	ADDRESS
Henry W. Means & Son	1057 N. Calvert St.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10047

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

92 D10047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 Monument St.; 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Reynolds

(Residence in Baltimore: No. 306 Monument place St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widowed

6-DATE OF BIRTH, ... Nov. (Month) 3rd (Day), 1859 (Year)

7-AGE, 58 yrs. 1 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Towson Maryland

PARENTS.

10-NAME OF FATHER, Frank Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Martha Baker

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Jennings

(Address) 306 Monument St.

15-

Filed 11/15, 1917 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2d, 1917, to Nov 10th, 1917, that I saw her alive on Nov 10th, 1917, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Chronic Heart Failure

(Duration) 1 yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ? yrs. ? mos. ? ds.

(Signed) Dr. Geo. F. Hall M. D.

11/15/17, 191... (Address) 1628 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Pleasant Rest Towson	Nov 14, 1917
20-UNDERTAKER Geo H Holland	ADDRESS 631 E Balto

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10048

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 White ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Smith

(Residence in Baltimore: No. 1913 White St

St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH. November 15, 1903
(Month) (Day) (Year)

7-AGE, 14 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James Smith

11-BIRTHPLACE OF FATHER (State or Country). Manchester, Va

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Smith

(Address) 1913 White St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1917
11 (Month) Sunday (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Nov 11 1917, that I saw him alive on Nov 11 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Primary (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Montague M. D.

Nov. 14, 191.7 (Address) 303 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Ceme

DATE OF BURIAL, Nov 14, 191.7

20-UNDERTAKER James H Dennis

ADDRESS 303 Presstman

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10049

CERTIFICATE OF DEATH.

D10049

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Parkwood Ave. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Hessong

(Residence in Baltimore: No. 2812 Parkwood Ave. St.: 20 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec. 13, 1870
(Month) (Day) (Year)

7-AGE, 46 yrs. 10 mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Poole & Hunt Co.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Thos. H. Hessong

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Margaret Mullin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabelle H. Hessong

(Address) 2812 Parkwood Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 10 1917, to Nov 12 1917, that I saw h[illegible] alive on Nov 12 1917, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Right Lung Complicated with Laryngitis)

Tuberculosis Cerebral Tuberculosis Contributory 7.14.17.

(Duration) yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary

(Duration) yrs. mos. 22 ds.

(Signed) P. C. B. Norment M. D.

Nov. 15, 1917. (Address) 3143 Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Nov. 15, 1917

20-UNDERTAKER Horace Burgee & Son — ADDRESS 363 Walbrook Road.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10050

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 W. Cross St ST. 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanna B. Hammerbacher alt

(Residence in Baltimore: No. 622 W. Cross St

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May (Month) 30 (Day) 1847 (Year)

7-AGE, 70 yrs. 5 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Hammer

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Susanna Hammer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrica Hammer

(Address) 622 W. Cross St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 11 (Day), 191? (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 191?, to Nov 11 191?, that I saw h alive on Nov 11 191?, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) .....yrs. .....mos. 12 ds.

CONTRIBUTORY (Secondary) Uraemia Coma

..... (Duration) .....yrs. .....mos. 3 ds.

(Signed) Wm Hammond Lee M. D.

Nov 13, 191?. (Address) 835 E 20th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk. DATE OF BURIAL, Nov 14th, 191?

20-UNDERTAKER Leo. G. Cook ADDRESS North Harford

mrs

Important. See instructions on back of certificate.

D16051

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 ✓ D16051

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2218 Eagle street St.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida M. R. Walter

(Residence in Baltimore: No. 2218 Eagle St.: 8 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: July 11, 1891 (Month) (Day) (Year)

7 AGE: 26 yrs. 4 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Paul H. Brohm

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Bomberg

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida M. Walter

(Address) 2218 Eagle st.

15.

NOV 14 1917 HARRY D. AS[illegible]

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 13, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 ....., 1916, to. Nov. 13 1917.

that I saw h[illegible] alive on Nov. 13 ....., 1917.

and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 3 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Oedema of Lungs

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed), Dan'l Grant M. D.

Nov. 13 ....., 1917 (Address) 1925 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: Nov 15 ....., 1917

20 UNDERTAKER: M S' Tintz — ADDRESS: 1921 W Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 17
8 4
3 3

10052 HEALTH DEPARTMENT—CITY OF BALTIMORE

10052

CERTIFICATE OF DEATH.

79 ✓

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 445 N. Bidde St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leah Bond

(Residence in Baltimore: No. 445 N. Bidden St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmale

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Autumn, 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. Autumn mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Woman 070
(b) General nature of industry, business, or establishment in which employed (or employer). Private 833

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Autumn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Autumn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dow

(Address) 445 N. Bidde

15-

Filed....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. mos. ds.
CONTRIBUTORY Senility
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Wathaway M. D.
(Coroner)
Nov 14, 191 7 (Address) 819 N Bdwy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State Md yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov 15, 19 17

20-UNDERTAKER Wm H. Harper

ADDRESS 406 N Eutaw St

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Omissions and errors are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10053 ✓ D10053

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Ridgley

(Residence in Baltimore: No. 530 Laurens St. St.; Yrs., mos., ds.) Lifetime

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	col.	single

6-DATE OF BIRTH, Unknown (Month) (Day) 1898 (Year)

7-AGE, 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer 043

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Ridgley

(Address) 530 Laurens St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 191 7, to Nov 14 191 7, that I saw h[illegible] alive on Nov 13 191 7, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Mitral & aortic regurgitation

(Duration) Dont know yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(Duration) Dont know yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 14, 191 7. (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 530 Laurens St.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, Nov 16, 191 7

20-UNDERTAKER Samuel Hamilton

ADDRESS 5[illegible]8 to Baddle

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10051 79 ✓ D10051

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lee Hall

(Residence in Baltimore: No. 1727 McCulloh St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) 1 (Day) (Year)

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Walter Hall

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Laura Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hall

(Address) 54 S Bridle St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9 1917, to Nov. 13 1917, that I saw h[illegible] alive on Nov. 13 - 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

1. Aortic Insufficiency
2. Cardiac decompensation
Dyst Sinus
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

Nov. 13, 1917. (Address) Md Gen Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1727 McCulloh St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Nov 13, 1917.

20-UNDERTAKER Emanuel Hemsley

ADDRESS 54 S Bridle

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10055

CERTIFICATE OF DEATH.

92 D10055

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. Ft. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Grant

(Residence in Baltimore: No. 922 Jenkins St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 1891
(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter 086
(b) General nature of industry, business, or establishment in which employed (or employer) In Bar Room

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Grant

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Gray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Grant

(Address) 922 Jenkins St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1917, to Nov 13 1917, that I saw him alive on Nov 13 1917, and that death occurred, on the date stated above, at 10½ m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Don't Know
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 13, 191.7. (Address) Md. General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State Life mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 922 Jenkins St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Nov 14 191...

20-UNDERTAKER Samuel Hensley ADDRESS 518 N Eutaw

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10056

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie C Glasser

(Residence in Baltimore: No. 120 N. Ellwood ave St.; 46 yrs., 8 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 24, 1869, 1
(Month) (Day) (Year)

7-AGE, 48 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Earnst Herman Katzkamer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Osterlow

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Glasser husband

(Address) 120 N Ellwood Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November, 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov. 13, 1917, that I saw h or alive on Nov. 13, 1917, and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis & Nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Jacobson M. D.

11-13, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 120 N. Ellwood ave

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov. 16, 1917.

20-UNDERTAKER Armstrong Lemmy & — ADDRESS N. Light st

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D10057

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James F Edmonds

(Residence in Baltimore: No. 1100 Light Street St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	white	single

6-DATE OF BIRTH, Sept. (Month) 18 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 1 mos. 26 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0 0 .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter Edmonds

11-BIRTHPLACE OF FATHER (State or Country) Calvert Co Md

12-MAIDEN NAME OF MOTHER Lily Bowen

13-BIRTHPLACE OF MOTHER (State or Country) Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Edmonds

(Address) 1100 Light st

15-

Filed....., 191.....

Registrar.

NOV 14 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 191 7, to Nov. 13 191 7, that I saw him alive on Nov. 12 191 7, and that death occurred, on the date stated above, at 6.10 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A. Bauer M. D.

Nov. 13, 191 7 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State ..... yrs. 6 mos. ..... ds.

Where was disease contracted, if not at place of death? 1100 Light St

Former or usual residence 1100 Light St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkwood Calvert Co Md	Nov. 15, 1917
20-UNDERTAKER	ADDRESS
Armstrong & Denny Co	715 Light st

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10058

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 Loudan Ave St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etta V. Frost

(Residence in Baltimore: No. 136 Loudan Av St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 25 (Day), 1892 (Year)

7-AGE, 25 yrs. 5 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Silas Pomeroy

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Martha Lehew

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Frost

(Address) 136 Loudan Av

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1917, to Nov 12 1917, that I saw her alive on Nov 12 1917, and that death occurred, on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 9 mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard W Jones M. D.

Nov. 13, 1917. (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov. 14, 1917.

20-UNDERTAKER Joseph B Cook ADDRESS 1003 Madison Ave

NOV 14 1917

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10059 D10059

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Holbrook St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Cassiday

(Residence in Baltimore: No. 1502 Holbrook St.; Like yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ Widowed (Write the word.)

6-DATE OF BIRTH, Feb 17, 1863 (Month) (Day) (Year)

7-AGE, 54 yrs. 8 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Railroad 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... Conductor

530

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Patrick Cassidy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Cassidy

(Address) 1502 Holbrook

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1917, to Nov 12 1917, that I saw h im alive on Nov 12 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

.....Chronic Nephritis.....

..... (Duration) 1 yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Wm P. Carr M. D.

Nov 13, 191 7. (Address) 5 E Preston

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 15th, 191 7.

20-UNDERTAKER, Chas F. Evans & Son — ADDRESS 118 W Mt Royal

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10060 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D10060

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2617 Dulaney St.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Moir Falahee

(Residence in Baltimore: No. 2617 Dulaney St.; ....yrs., ...mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alfred Fala Lee

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Katie.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Katie Fala Lee

(Address) 2617 Dulaney St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 191 7, to Nov 12 191 7, that I saw her alive on Nov 12 191 7, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Disorders and Enteritis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Norbert C Meisch M. D.

Nov 14, 191 7. (Address) 2249 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Nov 15, 191 7
20-UNDERTAKER Joseph B Cook	ADDRESS 1002 W Balto St

NOV 14 1917 Buried in all Souls

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D16061

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D16061

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Agnes Jennings

(Residence in Baltimore: No. 1801 Hanover St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, 1860
(Month) (Day) (Year)

7-AGE, ... 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas B. Jennings

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Winifred Conroy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin F. Jennings

(Address) 1801 Hanover St.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 12nd, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7th 1917, to Nov 12th 1917, that I saw h[illegible] alive on Nov 12th 1917, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

..... Most Probably Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. J. O'Donnell M. D.

Nov 14th, 1917. (Address) 1072 West St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem | DATE OF BURIAL, Nov. 15, 1917

20-UNDERTAKER M. J. Flynn | ADDRESS 452 Light

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10062 D10062

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Poplar Grove ST.; 15 WARD)

REGISTERED No. C 34

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Von Hagel

(Residence in Baltimore: No. 1902 Popular Grove St.; 29 yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 27, 1888 (Month) (Day) (Year)

7-AGE, 29 yrs. mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Hartman Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bertha Last

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Von Hagel

(Address) 1902 Poplar St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1917, to Nov 11 1917, that I saw h~ alive on Nov 11 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Consumption

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

Nov 14, 191. (Address) 835 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Nov. 14, 191.

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10063

CERTIFICATE OF DEATH.

91 D10063

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N Eden St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Earl Henson

(Residence in Baltimore: No. 428 N Eden St; 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 2 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel J. Henson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nora Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Henson

(Address) 428 N Eden St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 12 1917, that I saw h alive on Nov 12 1917, and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) 2 yrs. 6 mos. ds.

(Signed) J. Edward Fisher M.D.

Nov 13, 1917 (Address) 1612 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov 14 1917

20-UNDERTAKER Milton Davis

ADDRESS 413 N Eden St

Important. See instructions on back of certificate.

D10061

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10061

CERTIFICATE OF DEATH

92

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 W Lombard St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberta G Zelvis

(Residence in Baltimore: No 848 W. Lombard St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	single

6-DATE OF BIRTH: Jan. (Month) 17 (Day), 1917 (Year)

7-AGE: yrs. 9 mos. 11 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None. 000

9-BIRTHPLACE (State or country) Baltimore Maryland

PARENTS

10-NAME OF FATHER: Chas. Zelvis

11-BIRTHPLACE OF FATHER (State or country): Lithuania

12-MAIDEN NAME OF MOTHER: Agnes. Raslavich

13-BIRTHPLACE OF MOTHER (State or country): England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Zelvis

(Address) 848. W. Lombard St.

15-

Filed ....., 191.....

REGISTRAR

NOV 14 1917 ROBERT P. KNAUER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1917, to, Nov 13 1917, that I saw h[illegible] alive on Nov 13 1917, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs mos. 4 ds.

Contributory (SECONDARY) .....

(Duration) yrs. mos. ds.

(Signed), Otto J Boyd M. D.

Nov 14, 191 7 [Address] 402 Cal

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Nov. 15. 1917.

20-UNDERTAKER: John Grebiancka. ADDRESS: 425. S. Paca St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill out all items. Do not use abbreviations. Be sure to answer every question. Write plainly with pen and ink. Do not use lead pencil. Do not write on back of certificate. ATTENTION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

John - Lukaszwski

D16065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hosp

CITY OF BALTIMORE: (No. Cambria & Aliceanna ST.; 5 WARD)

REGISTERED No. C 1720 D16065

2-FULL NAME John ~~Frida~~ Lukaszwski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1726 Aliceanna St. (Knows as Priel) 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1865 (Year)

7-AGE, 52 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work Butts Burgon
(b) General nature of industry, business, or establishment in which employed (or employer) Home Hosp Abattoir Man

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, August Lukaszewski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Anna Mistelski

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ownlma Lukaszewska

(Address) 1726 Aliceanna St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1917, to Nov 13 1917, that I saw h[illegible] alive on Nov 13 1917, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

a Cardiac & Pneumonia

b Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abortment

(Duration) yrs. mos. 7 ds.

(Signed) Thomas Mistel M. D.

, 191... (Address) 1532 A

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Don't Know

Former or usual residence 1726 Aliceanna St

19-PLACE OF BURIAL, OR REMOVAL, St. Stanislaus — DATE OF BURIAL, N.V.16., 1917.

20-UNDERTAKER W. F. Sadowski — ADDRESS 705 S. Ann

Important. See instructions on back of certificate.

NOV 14 1917 ROBERT R. KRAUTER BURIAL PERMIT

Spec.—8-24-14—M. & T.—2000 Bks.

MH U. 2135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.16066

CERTIFICATE OF DEATH.

X 120

D16066

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary, ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Crane

(Residence in Baltimore: No. ..... St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower.

6-DATE OF BIRTH, December 12, 1885
(Month) (Day) (Year)

7-AGE, 31 yrs. 10 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machine 031
(b) General nature of industry, business, or establishment in which employed (or employer): Operator.

311

9-BIRTHPLACE, (State or Country), Kansas

PARENTS.

10-NAME OF FATHER, S. H. Grier

11-BIRTHPLACE OF FATHER (State or Country), Tennessee

12-MAIDEN NAME OF MOTHER Julia B. Albright

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kerrigan

(Address) Maryland Penitentiary

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 12, 1917, to November 9, 1917, that I saw him alive on November 9, 1917, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - Cardiac and Respiratory Failure.

(Duration) 5 yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemic Nephritis

(Duration) ..... yrs. 10 mos. ..... ds.

(Signed) William F. Schwartz M. D.

Nov. 10, 1917. (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 9 mos. 16 ds. In the State Ark. yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Kansas

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	NOV 14 1917, 191...
20-UNDERTAKER	ADDRESS

NOV 14 1917 ROBERT R. REAMER Burial Permit Clerk

Commissioner Health.

For Wm. T. WOODLEY.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 10067

CERTIFICATE OF DEATH.

170

D 10067

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Hickory Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen H Gray

(Residence in Baltimore: No. 3708 Hickory Ave St.; 30 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, 12 (Month) 9 (Day) 1852 (Year)

7-AGE, 64 yrs. 11 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 218 015

9-BIRTHPLACE, (State or Country), Ann Arundel Co.

PARENTS.

10-NAME OF FATHER, Stephen grey.

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co. Md

12-MAIDEN NAME OF MOTHER Sarah Jacobs.

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Burnett

(Address) 3708 Hickory Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-22 1917, to 11-12 1917, that I saw h[illegible] alive on 11-12 1917, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. T. Douglas M. D.

11/13, 1917. (Address) 3801 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. | DATE OF BURIAL, Nov. 15..., 1917

20-UNDERTAKER Joseph B Cook | ADDRESS 1003 N. Bond St

NOV 13 1917 ROBERT N. KNAUER BURIAL PERMIT

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10068 D10068

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Hollins ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Webb

(Residence in Baltimore: No. 1913 Hollins St; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1916 (Year)

7-AGE, 1 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, W. Webb

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Marie Webb

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Webb

(Address) 1913 Hollins st

15-

Filed....., 191.....

Registrar.

NOV 14 1917 ROBERT R. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1917, to Nov 14 1917, that I saw h~~im~~ alive on Nov 14 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 1 ds.

(Signed) W. F. Webb M. D.

....., 191... (Address) 1913 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 15 191 7

20-UNDERTAKER Robert Brookeman — ~~Brookeman~~ Hollins st

important. See instructions on back of certificate.

D10069

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

D10069

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 East Randall St.; 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and nomber and fill out No. 18.)

2-FULL NAME William Asbury Thomas

(Residence in Baltimore: No. 139 E Randall St; ..... St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: August (Month) 22 (Day) 1844 (Year)

7-AGE: 73 yrs. 2 mos. 20 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired Steamboat Captain
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Joseph Thomas

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.m Thomas

(Address) 139 E Randall St

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12, 1917, to, Nov 12 1917, that I saw h.m alive on Nov 12 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (SECONDARY) Chronic Nephritis

autumn (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Dunton M. D.

11/13 1917 [Address] 301 E Lanvale St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill

DATE OF BURIAL: Nov 15, 1917

20-UNDERTAKER: E J Fanning

ADDRESS: 1460 Baltimore

State CAUSES OF DEATH in plain words, so that a non-medical person can understand them. Do not use abbreviations or technical terms. Carefully FOLLOW THE INSTRUCTION is very important. See instructions on back of certificate.

D10070

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 D10070

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 921 N. Carey st St.: 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary A. C. Myers

(Residence in Baltimore: No. 921 N. Carey St St.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem.

4 COLOR OR RACE White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 12, 1841 (Month) (Day) (Year)

7 AGE 76 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John Carrick

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Annie Downs

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George E. Myers

(Address) 921 N. Carey St

15.

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 13th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1917, to Nov 13th 1917.

that I saw h~~er~~ alive on Nov. 13th, 1917.

and that death occurred on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 6 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), N E Jones M. D.

Nov 15, 1917 (Address) 1235 W Lafayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Loudon Park Burial Place

DATE OF BURIAL Nov 15, 1917.

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 W. Fayette

NOV 14 1917 ROBERT D. LAUTER BURIAL PERMIT CLERK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D10071

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1828 Ruddock St. WARD 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Albert McCartman

(Residence in Baltimore: No. 1828 Ruddock St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, Oct 19 (Month) (Day), 1854 (Year)

7-AGE, 65 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), Ohio,

PARENTS.

10-NAME OF FATHER, Wm S. Wortman

11-BIRTHPLACE OF FATHER (State or Country), Ohio,

12-MAIDEN NAME OF MOTHER Lucinda Layman

13-BIRTHPLACE OF MOTHER (State or Country), Ohio,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W P Buchanan

(Address) 1730 E Baltimore St

15-

NOV 14 1917 ROBERT B. KRAUTER Burial Permit

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

Nov 12, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	Nov 15, 1917.
20-UNDERTAKER W J Settlemeyer & Son	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 30

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10072 D10072

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. Patterson Park Ave ST.: 1 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosina Krug

(Residence in Baltimore: No. 26 E. Patterson Park Ave St.: 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 19 (Day), 1852 (Year)

7-AGE, 65 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. John Kaus

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Krug

(Address) 26 E. Patterson Pk Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 191 , to Nov 12 191 , that I saw her alive on Nov 12 191 , and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. N. Bluey M. D.

Nov. 14, 191. (Address) 100 S. Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Conn, DATE OF BURIAL, Nov. 15, 1917.

20-UNDERTAKER H. Lauder Sons ADDRESS 1710 Eutaw St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10073

CERTIFICATE OF DEATH.

80

D10073

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Eutaw Place ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Siegel

(Residence in Baltimore: No. 2311 Eutah Place St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. Nov (Month) 11 (Day) 1862 (Year)

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). Grocer 045

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Siegel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER H. Hamburger

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sidney Rosenthal

(Address) 2433 Eutaw Pl.

15-

NOV 11 1917 ROBERT B. KRAUTER Burial Permit

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22 1917, to Nov. 13 1917, that I saw h*im* alive on Nov. 13 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Coronary) Artery Thrombus

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Coronary)

(Duration) 5 yrs. mos. ds.

(Signed) Isaac L. Hamburger M. D.

Nov. 14, 1917 (Address) 1207 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bells Hebrew Cem

DATE OF BURIAL, Nov. 15, 1917

20-UNDERTAKER J. Abrams & Co

ADDRESS 1611 Madison

Important. See instructions on back of certificate.

George H. Graf.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10077

CERTIFICATE OF DEATH.

170 D10077

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1721 N Broadway St.) (WARD) 8

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Graf

(Residence in Baltimore: No. 1721 N Broadway St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
50 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Carl Graf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Graf

(Address) 1721 N Broadway

15-

NOV 11 1917 ROBERT R. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions
Nephritis
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(Secondary)
(Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)
Nov 13, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Nov. 14th, 1917.
20-UNDERTAKER	ADDRESS
Geo Schillinger Sons	Monument Sq

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10075 — 79 — D10075

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Patapsco St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mary Eichhorn.

(Residence in Baltimore: No. 1109 Patapsco St. St.; 60 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Widow.

6-DATE OF BIRTH, January 27th. 1839. (Month) (Day) (Year)

7-AGE, 78 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louis Wise. (daughter)

(Address) 1109 Marshall St.

15-

Filed....., 191.....

Registrar.

NOV 14 1917 ROBERT B. KRAUTER Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11th. 1917. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Edw. M. Beinhardt, M. D. (Coroner.)

Nov. 14th. 191 7 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	11/15, 19 17
20-UNDERTAKER,	ADDRESS,
E & B Hale	115 E West St

D10076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10076

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 853 E Pine St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen D. Cooper

(Residence in Baltimore: No. 853 E Pine St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery 24 3 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Cooper

(Address) 919 Leadenhall

15-

Filed....., 191.....

ROBERT A. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Driscoll M. D.
(Coroner.)

Nov 13, 1917 (Address) 124 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER Wm H. Coard & Son

ADDRESS 400 Mosher

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D1007 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D1007

40

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Christian ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny F Linkeman

(Residence in Baltimore: No. 2204 Christian St. St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1868 (Year)

7-AGE, 49 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levis

(Address) 1411 E Balt

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Nov 14 1917, that I saw h is alive on Nov 14 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of Liver

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Ascites

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) M. Schneider M. D.

Nov 15, 1917 (Address) 210 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	Nov 15, 1917
20-UNDERTAKER	**ADDRESS**
Jack Levis	1411 E Balt

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D16078

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

186 D16078

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Biddle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Washington

(Residence in Baltimore: No. 427 Bidder St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE 73 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country) Washington D.C.

PARENTS.

10-NAME OF FATHER, Antony Brown

11-BIRTHPLACE OF FATHER (State or Country) Washington, D.C.

12-MAIDEN NAME OF MOTHER Sophia Brown

13-BIRTHPLACE OF MOTHER (State or Country) Washington, D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Mason

(Address) 427 Bidder St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1915, to Nov. 12th 1917, that I saw h— alive on Nov. 12th 1917, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) V.H. Von Ellis M. D.

Nov 14, 1917, (Address) 2 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Nov 15, 1917

20-UNDERTAKER Edmund J. Hensley ADDRESS 5 & 8 W. Biddle

HARRY O. ANDREWS
NOV 15 1917
Registrar

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10079 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10079

28

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 Green mount Ave; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Campbell

(Residence in Baltimore: No. 2307 Green Mount Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Don't know ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE,	If LESS than 1 day,
51 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Wallschlager

(Address) 548 Cottage Ave

15-

Filed ....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1917, to Nov 13th 1917, that I saw her alive on Nov 13th 1917, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos Burgan M D M. D.

Nov 13th, 1917. (Address) 3537 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Nov. 16, 1917.
20-UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

Important. See instructions on back of certificate.

D10080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

D10080

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St. 9 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Amos McMillion

(Residence in Baltimore: No. 1723 Hanover St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 328 150

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, James McMillion

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James McMillion

(Address) 1723 Hanover St.

15-

Filed....., 191.....

Registrar.

NOV 15 1917 HARRY C. ANDREWS Special Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 12 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner.)

Nov. 13, 191 7 (Address) 926 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem[illegible]	Nov. 15, 1917
20-UNDERTAKER	**ADDRESS**
George J. Rentz	1735 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Also statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N. Chester ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas W. Colison

(Residence in Baltimore: No. 1805 N. Chester St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 26 (Month) (Day), 1856 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 1 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer): Builder

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Colison

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Sarah Walton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Sarah Colison wife
(Address) 1805 N. Chester

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov 13 1917, that I saw h alive on Nov 12 191, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Nov 14, 1917 (Address) 1321 N Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Nov 15, 1917

20-UNDERTAKER	ADDRESS
Robt F Turner	1442 N Broadway

NOV 15 1917 HARRY D. AN LEWIS

Spec.—8-24-14—M. & T.—2000 Blks.

D10082 ✓ D10082

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Nursery and Child's Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther L. Evans.

(Residence in Baltimore: No. Nursery and Child's Hosp. St.; ..... yrs., ... mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... June (Month) 19th (Day) 1917 (Year)

7-AGE, ... yrs. 4 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) —— 000

9-BIRTHPLACE, (State or Country), Cambridge, Md.

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. T. Ja Rue

(Address) Nursery & Child's Hosp.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 13 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 191 7, to Nov 13 191 7, that I saw her alive on Nov 13 191 7, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldberg M. D.

11-14, 191.7 (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 29 ds. In the State ..... yrs. ..... mos. 29 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Cambridge Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov. 15, 1917.
20-UNDERTAKER Geo J Smith	ADDRESS 1008 E Fayette St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10083 64 D10083

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cecil Apartments St.; 91 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Krusilla Carter Langdon

(Residence in Baltimore: No. Cecil Apts St.; 16 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb (Month) 19th (Day), 1864 (Year)

7-AGE,	If LESS than 1 day,
53 yrs. 8 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) 606 000

9-BIRTHPLACE, (State or Country), Louisville Ky.

PARENTS.

10-NAME OF FATHER, Kearsley Carter

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Sally R Douglass

13-BIRTHPLACE OF MOTHER (State or Country), New Orleans.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D. Carter

(Address) Fredericksburg Va.

15-

NOV 15 1917 ROBERT E. KRAUTHOFF

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12th 1917, to Nov 14th 1917, that I saw her alive on Nov 13th 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage; Hemiplegia right side; Delirium Coma; Lower Lobe Pneumonia ..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Possible Arterio Sclerosis ..... (Duration) ? yrs. .....mos. .....ds.

(Signed) Thomas L Sheppard M. D.

Nov 15th, 1917. (Address) 905 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Louisville Ky.	Nov 16th, 1917
20-UNDERTAKER Henry H Jenkins Sons & Co	ADDRESS McCulloh & Eutaw

Important. See instructions on back of certificate.

17
79
38 D10081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10081

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1729 N. Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lonnie V. Williams

(Residence in Baltimore: No. 1729 N Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day), 1838 (Year)

7-AGE, 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Woman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper 100

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Laura Deems

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) 1729 N Carey

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Nov. 14, 1917. (Address) 819 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 79 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 17, 1917

20-UNDERTAKER W J Tilden Sons — ADDRESS Pennsylvania Ave

important. See instructions on back of certificate.

NOV 15 1917 ROBERT R. TRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D1C085

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 ✓ D1C085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Exeter St 5 St.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paulina Cesenaro

(Residence in Baltimore: No. 408 N. Exeter St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, April (Month) 27 (Day), 1915 (Year)

7-AGE. 2 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Giusto Cesenaro

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Maria Prerit

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giusto Cesenaro

(Address) 408 N. Exeter St.

15-

Filed....., 191.....

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1917, to Nov 14 1917, that I saw her alive on Nov 14 1917, and that death occurred, on the date stated above, at 12 10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Luigi D. Di Stefano M. D.

Nov 15, 1917 (Address) 407 N Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cem. DATE OF BURIAL, Nov. 16, 1917

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Mary G. Trotto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10086 ✓ X131 D10086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Biddle & Saltman Sanatarium REGISTERED NO. C

CITY OF BALTIMORE, (No. 1 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary, V[illegible]spanota, Trotto.

(Residence in Baltimore: No. Bethel St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
33 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vito Trotta

(Address) 3607 E. Pratt

15- Nov 7

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov, 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov, 12, 1917, to Nov 14 1917, that I saw h[illegible] alive on Nov 14 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) .....yrs.....mos.....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3607 E. Pratt St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	Nov. 17 191.7

20-UNDERTAKER John Herring & Co

ADDRESS 2008 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10087 — X30 — D10087

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Mary Magdalene Farrell

(Residence in Baltimore: No. Childrens Aid Society St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH, November 2, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Richard Farrell

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Smith

(Address) Johns Hopkins Hospital

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Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 30 191 , to November 10 191 , that I saw her alive on November 10 191 , and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

tuberculous meningitis

..... (Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) W. H. Rowe M. D.

M.V. 11, 191.. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1½ ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Overlea, Balto. Co., Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	NOV 13 1917 ....., 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

NOV 9 1917 JOSEPH E. KRAUTER Registrar

Important: Give information on other side of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10088

91 ✓

1-PLACE OF DEATH Md. General Hosp. 14

REGISTERED NO. C D10088

CITY OF BALTIMORE: (No. ..... St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Martin

(Residence in Baltimore: No. 1533 Linden Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	

6-DATE OF BIRTH. ....., 1 .....
(Month) (Day) (Year)

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or estsblishment in whicb employed (or employer) 040

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9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, do not know

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Roberts - Md.

(Address) Md General Hospital

15-

Filed ....., 191.....

NOV 15 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1917, to Nov. 13 1917, that I saw h.. alive on Nov. 12 1917, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M. D.

Nov 13, 191. (Address) Md General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Camp Meade

Former or usual residence 1533 Linden Ave.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS

Commissioner Health.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10089

CERTIFICATE OF DEATH.

79 ✓

REGISTERED NO. C. D10089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Chapel ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Roberts

(Residence in Baltimore: No. 112 N. Chapel St.; 2 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Black a. g.	Married

6-DATE OF BIRTH, ... January ..... (Month), ~ (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ~ mos. ~ ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country). W. West Indies

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adaline Roberts

(Address) 112 N. Chapel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1917, to Nov. 13, 1917, that I saw h[illegible] alive on Nov. 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) ..... M. D.

11/14 1917. (Address) 1520 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel cemtery

DATE OF BURIAL, Nov 16 1917

20-UNDERTAKER Milton Davis

ADDRESS 413 N Eden St

Spec.—8-24-14—M. & T.—2000 Bks.

D10090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H D10090

REGISTERED NO. C

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 11 Mount St. Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Griffith

(Residence in Baltimore: No. 422 Fawcett St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 29 (Day) 1868 ~~1917~~ (Year)

7-AGE, 49 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ~~Home~~

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, David Beck

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alverda E. Mercer

(Address) 504 Montello Norfolk Va

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/10 1917, to 11/15 1917, that I saw her alive on 11/13 1917, and that death occurred, on the date stated above, at 12-0 m.

The CAUSE OF DEATH* was as followa:

Carcinoma of Bladder

Operation (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. W. De Holt M. D.

11/15, 191.7 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State 49 yrs. 4 mos. 17 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 422 Fawcett St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Hayden	Nov. 16., 191.7.
20-UNDERTAKER	ADDRESS
William Cork	504 E North

NOV 15 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10091

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3728 old Frederick Rd St.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph O'Brien

(Residence in Baltimore: No. 3728 old Frederick Rd St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 18 (Day), 1839 (Year)

7-AGE, 78 yrs. 6 mos. 17 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardner
(b) General nature of industry, business, or establishment in which employed (or employer): 886

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Daniel O'Brien

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary Bulger

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elno O'Brien

(Address) 372 old Fred. Rd

15-

Filed ....., 191.....

NOV 15 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 14 1917, that I saw h... alive on Nov 14 1917, and that death occurred, on the date stated above, at 5.35 P.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

..... (Duration) Indefinite yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard W Jones M. D.

Nov 15, 1917. (Address) Irvington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Cemetery

DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER Joseph B Cook

ADDRESS 1003 W Balto St

Spec.—5-19-13—M. & T.—500 Bks.

D10092 D10092 154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH General German Aged Home

CITY OF BALTIMORE: (No. Baltimore Payson ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Christine Müller

(Residence in Baltimore: No. N. E. Cor. Baltimore Payson St. St.; 67 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 24, 1830 (Month) (Day) (Year)

7-AGE, 87 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country) Nurberg Bayern Germany

PARENTS.

10-NAME OF FATHER, John Adam Gerwart

11-BIRTHPLACE OF FATHER (State or Country), Bayern

12-MAIDEN NAME OF MOTHER Anna Ruppert

13-BIRTHPLACE OF MOTHER (State or Country), Bayern

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of German Aged Home

(Address) Balto & Payson Sts.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1915, to Nov. 1917, that I saw h[illegible] alive on Nov. 12 1917, and that death occurred, on the date stated above, at 3 30 A.m.

The CAUSE OF DEATH* was as follows:

[illegible] Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. N. Hollaman M. D.

Nov. 15, 1917 (Address) 1908 N. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. ds. In the State 67 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem Co Hyatt | DATE OF BURIAL, Nov. 17, 1917

20-UNDERTAKER J. R. Cook | ADDRESS 1003 W. Balto St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10093

CERTIFICATE OF DEATH.

D10093

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2159 Hollins ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Haigley

(Residence in Baltimore: No. 2159 Hollins St

St.; Fifty Years 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 26 (Month) (Day), 1868 (Year)

7-AGE, 49 yrs. 5 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Police Officer
(b) General nature of industry, business, or establishment in which employed (or employer) 061

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Alphons Haigley

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Margaret Rais

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Haigley

(Address) 2159 Hollins St

15-

Filed....., 191.....

NOV 15 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13th 1917, to Nov 13th 1917, that I saw h m alive on Nov 13th 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

1. Acute Dilatation of Heart

(Duration) yrs. mos. 24 hrs ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 1 mos. ds.

(Signed) J. J. O'Donnell M. D.

Nov 15th, 1917. (Address) 1073 Wash St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Eastern Cemetery

DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER Geo A Terby

ADDRESS Baltimore

D10091

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10091

1 PLACE OF DEATH

REGISTERED No. C 120

CITY OF BALTIMORE: (No. 1404 W. Pratt St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Wiffield

(Residence in Baltimore: No. 1404 W. Pratt St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug. 16, 1872 (Month) (Day) (Year)

7-AGE: 45 yrs. 3 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
X 037

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: James McCartee

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Elyza Dunn

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. McCartee

(Address) 1518 W Pratt st

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 15 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1917, to Nov. 14, 1917, that I saw her alive on Nov. 14, 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY): Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) E. A. Dickey M. D.

Nov. 15, 1917 [Address] 14 N. Monroe St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Nov 19, 191.

20-UNDERTAKER: George E. Farley ADDRESS: Fulton & Fayette Sts

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 10095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 10095

CERTIFICATE OF DEATH. Mellier 9r

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Woman's Hospital St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth B. Mellier Mellier

(Residence in Baltimore: No. 1406 Linden Ave St.; 44 yrs., 1 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, (1873) Oct. 10, 1873 (Month) (Day) (Year)

7-AGE, 44 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Wm H. H. Bixler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Elizabeth Bowa

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H H Bixler

(Address) 1406 Linden Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1917, to Nov 16 1917, that I saw h er alive on Nov 16 1917, and that death occurred, on the date stated above, at 2.20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 4 ds.

(Signed) Hattie M. Clarke M. D.

Nov. 16, 1917. (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 10 ds. In the State 44 yrs. 1 mos. 6 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 1406 Linden Ave

19-PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL, Nov. 19, 1917.

UNDERTAKER Stewart Memorial Co. ADDRESS 108 W. North Ave

8

Spcc.—8-24-14—M. & T.—2000 Pks.

D16096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D16096

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Dallas St, ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Master Thomas H Marron,

(Residence in Baltimore: No. 1618 Dallas St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, July 17th, 1912.
(Month) (Day) (Year)

7-AGE, X yrs. X mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X

000 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Marron

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Martha Gale

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Martha Marron Mother

(Address) 1618 N Dallas

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1917, to Nov. 14 1917, that I saw him alive on Nov. 14 1917, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

other

X (Duration) X yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Cerebral

X (Duration) X yrs. X mos. X ds.

(Signed) Dr. Geo F Hall M. D.

11/15/17 1917. (Address) 1628 N. Dallas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. 3 mos. 1 ds. In the State X yrs. 3 mos. X ds.

Where was disease contracted, if not at place of death? X

Former or usual residence 1

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetary	Nov. 16, 1917.
20-UNDERTAKER	ADDRESS
Inez R Elliott	506 East Fay

D1009?

HEALTH DEPARTMENT—CITY OF BALTIMORE.

92

D1009?

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1702 n Caden St.; 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Cland Gaines.

(Residence in Baltimore: No. 1702 n Caden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 039
(b) General nature of industry, business, or establishment in which employed (or employer) Gen

9-BIRTHPLACE, (State or Country), Va,

PARENTS.

10-NAME OF FATHER, Thos Gaines

11-BIRTHPLACE OF FATHER (State or Country), Va,

12-MAIDEN NAME OF MOTHER Mary Carter

13-BIRTHPLACE OF MOTHER (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elliott

(Address) Dutton n.

15-

Filed ....., 191.....
Registrar.

NOV 16 1917 ROBERT R. KRAUTER Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 191?.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Chesney M. D.
(Coroner.)

Nov 15, 191? (Address) 41 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	Nov. 16 1917

20-UNDERTAKER	ADDRESS
Mrs R A Elliott	506 East St

Important. See instructions on back of certificate.

S.

Spec.—5-19-13—M. & T.—500 Bks.

D10098

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D10098

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Lowman St ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennett E. Rice

(Residence in Baltimore: No. 1419 Lowman St

St.; ...yrs., ...mos. ...ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Oct. (Month) 29 (Day), 1917 (Year)

7-AGE, ... yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. H. Rice

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Lilly Wilder

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Rice

(Address) 1419 Lowman

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 1917, to Nov 14 1917, that I saw her alive on Nov. 13 1917, and that death occurred, on the date stated above, at 2, a. m.

The CAUSE OF DEATH* was as follows:

..... Capillary Bronchitis .....

..... (Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Sudden Change of Temperature

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. T. Seabury M. D.

Nov. 14, 1917. (Address) 621 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cemetery — DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER Wm. J. E. Evans Son — ADDRESS 1420 E. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D10099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10099

CERTIFICATE OF DEATH.

REGISTERED No. C 1047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 W. Hamburg ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley W. Ringrose

(Residence in Baltimore: No. 1115 W. Hamburg St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 11 (Day), 1916 (Year)

7-AGE, 1 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....None.....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, George Ringrose

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Catherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Catherine Ringrose

(Address) 1115 W. Hamburg St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov 14 1917, that I saw h— alive on Nov 13 1917, and that death occurred, on the date stated above, at 1000 m.

The CAUSE OF DEATH* was as follows:

Acromia Intestinal
Indigestion.

(Duration)...yrs. 1 mos...ds.

CONTRIBUTORY (Secondary) Endocarditis.

(Duration)...yrs...mos. 3 ds.

(Signed) E V Carmichael M. D.

11/15/17 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	Nov. 16, 1917.
20-UNDERTAKER	**ADDRESS**
Jones & Bryan & Son	1000 S. Paca St

D10100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10100

CERTIFICATE OF DEATH.

157

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital St.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Smith

(Residence in Baltimore: No. 1741 Carlisle place St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	col	Sgl

6-DATE OF BIRTH, May 26, (Month) (Day) 1911 (Year)

7-AGE, 6 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John L Smith

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Marie Perry.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Smith

(Address) 1741 Carlisle

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns; Generalized
visible following
fire in kitchen

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Nov 14, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Fairmount Cemetery DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER P E Ross ADDRESS 1805 McElderry St

important. See instructions on back of certificate.

ROBERT B. KRAUPP
NOV 16 1917
BURIAL PERMIT CLERK

D10101 HEALTH DEPARTMENT—CITY OF BALTIMORE D10101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 5 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert [illegible] Williams

(Residence in Baltimore: No. 1234 Calvin St.; yrs,. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Widd

6-DATE OF BIRTH, ... (Month), 1 (Day) ..... (Year)

7-AGE, 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) .....

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Probably Cerebro Embolism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley M. D.
(Coroner.)

Nov 16, 191... (Address) No. 39 Paradise

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov. 16, 19.7
20-UNDERTAKER	ADDRESS
R. E. Brooks	1435 McElderry St

important. See instructions on back of certificate.

NOV 16 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10102

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S Kenwood Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L Whittington

(Residence in Baltimore: No. 600 S Kenwood Ave St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 10, 186[illegible]
(Month) (Day) (Year)

7-AGE, 51 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, [illegible] Kenn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Matilda J Russell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda J Whittington

(Address) 600 S Kenwood Ave

15-

Filed Nov 16 1917 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Nov 14 1917, that I saw him alive on Nov 14 1917, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) 6 yrs. mos. ds.

(Signed) Geo Miller M. D.

11-16, 191.. (Address) 1937 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedarfield Md — DATE OF BURIAL, Nov 16 1917

20-UNDERTAKER Ralph Skinner — ADDRESS 1442 N Mary

Spec.—8-24-14—M. & T.—2000 Bks.

D10103 ✓ D10103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 E Federal St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E Johnson

(Residence in Baltimore: No. 1739 E Federal St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 21, 1866
(Month) (Day) (Year)

7-AGE, 50 yrs. 10 mos. 14 ds.

If LESS than 1 day, ...hrs. or .....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Elijah H Johnson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary M Scott

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie V Johnson

(Address) 1739 E Federal

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1916, to Nov 14 1917, that I saw h.. alive on Nov. 14 1917, and that death occurred, on the date stated above, at 1230 a m.

The CAUSE OF DEATH* was as follows:

(a) Primary Pulmonary Tuberculosis

(b) Secondary Tuberculosis Meningitis

(c) Abt 15 mos (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. S. Raley M. D.

Nov 15, 1917 (Address) 1637 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER, Robt J Turner — ADDRESS 1742 N Monday

D10101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 167

CITY OF BALTIMORE (No. Md General Hosp. WARD 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus Lindsay.

(Residence in Baltimore: No. 109 S St. Sparrows Pt. St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James Lindsay

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Department

(Address) Sparrows Pt.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burn
Accidental
(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) F. Edward Smith M. D.
(Coroner)

Nov. 15, 191 7 (Address) 900 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. 6 mos. ..... ds.

Where was disease contracted, if not at place of death? Sparrows Point

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Surry Court House Va — DATE OF BURIAL, Nov. 16., 1917

20-UNDERTAKER ARMSTRONG-DENNY CO. — ADDRESS 715 Light St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10105

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D10105

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N. Eutaw ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl F. Geyer

(Residence in Baltimore: No. 1124 N. Eutaw St.: 65 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 20, 1830 (Month) (Day) (Year)

7-AGE, 86 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Music Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles G. Geyer Jr.

(Address) 508 Park Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 14 1917, that I saw him alive on Nov 14 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Henry C. Dietz M. D.

Nov 15, 1917. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER John C. Mitchell — ADDRESS 1201 W. Fayette St

Important. See directions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10106

CERTIFICATE OF DEATH.

92

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Wall St ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M Coady

(Residence in Baltimore: No. 1215 Wall St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 20th (Month) 1915, (Day) 1 (Year)

7-AGE, 2 yrs. 10 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thomas Joseph Coady

11-BIRTHPLACE OF FATHER (State or Country), Phila. Pa.

12-MAIDEN NAME OF MOTHER Mary A. Pruett

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Coady

(Address) 1215 Wall st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Nov 14 1917, that I saw h[illegible] alive on Nov 14 1917, and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. ....ds.

(Signed) W J O'Donnell M. D.

Nov 15, 191.. (Address) 1015 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER John J Fahey & Sons

ADDRESS 1318 Light St

NOV 16 1917 ROBERT B. RADCLIFFE REGISTRAR VITAL STATISTICS BALTIMORE CITY

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10107

HEALTH DEPARTMENT—CITY OF BALTIMORE

47

D10107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 Dillon ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R. Young.

(Residence in Baltimore: No. 3112 Dillon St. St.; 8 yrs., 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 2nd, 1908
(Month) (Day) (Year)

7-AGE, 8 yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... at School

9-BIRTHPLACE, (State of Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Chas H. Young

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Katharine Kavanaugh

13-BIRTHPLACE OF MOTHER (State or Country), Boston Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H. Young.

(Address) 3112 Dillon St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Nov 14 1917, that I saw h[illegible] alive on Nov 13 1917, and that death occurred, on the date stated above, at 7 1/2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes of heart.

(Duration) yrs. 3 mos. ds.

(Signed) M. J. McAvoy M. D.

, 191... (Address) 839 S. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Catholic Cemetery

DATE OF BURIAL, Nov. 17 1917.

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Mo[illegible] St.

Spec.—8-24-14—M. & T.—2000 Bks.

Rabinowitz

D10108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10108

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Albemarl ST.; 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sarah Rabinowitz

(Residence in Baltimore: No. 205 Albemarl St.: 15 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Unknown ....., 1 ..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
55 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jussil Bromberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Isabel

(Address) 205 Albemarl St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 15 ....., 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16" 191 7, to Nov 15" 191 7, that I saw h[er] alive on Nov 15" 191 7, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

..... Toxemia

..... Interstitial

..... (Duration) yrs. mos. 1 ds.

Chronic Nephritis & Mitral Regurg

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) yrs. mos. ds.

(Signed) A. C. Ries M. D.

Nov 16", 191 7. (Address) 24 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 205 Albemarl St

19-PLACE OF BURIAL OR REMOVAL, Fitzw Blair Rd — DATE OF BURIAL, Nov 16, 191 7

20-UNDERTAKER Max Levinson — ADDRESS 1107 E Balt

D10109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10109

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Epstein

(Residence in Baltimore: No. 513 S. Carlin Dr St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, Unknown ....., 187.. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
50 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Lewis .....

(Address)..... 1411 E. Baltimore St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 16, (Day) 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, Accidental, ... burning clothes, fire from ..... stove.

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) J. J. Mc Laughlin M. D. (Coroner.)

Nov. 16 191.. (Address) 1411 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State 40 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	Nov. 16, 191..
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore St

important. See instructions on back of certificate.

NOV 16 1917 ROBERT E. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10110

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Mercy Hospital ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L Griggith

(Residence in Baltimore: No. Mercy Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word.)
Male	Black	Single

6-DATE OF BIRTH, Sept 26, 1913
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 1 mos. 20 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Giles Griffith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Della Linder

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 191..., to Nov 10 191..., that I saw him alive on Nov 10 191... and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Abdomen

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stomach Liver

(Duration) yrs. mos. ds.

(Signed) Edward L. Smith M. D.

Nov 11, 1917 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 1 ds. In the State ...yrs. 6 mos. ...ds.

Where was disease contracted, if not at place of death? Sykesville Md

Former or usual residence Sykesville Md

19-PLACE OF BURIAL OR REMOVAL, West Liberty, Md. DATE OF BURIAL, Nov 14 191 7

20-UNDERTAKER Jas. R. Weer ADDRESS Sykesville Md.

Spec.—8-24-14—M. & T.—2000 Bks.

D10117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10117

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CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. 714 Forrest St. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hannan

(Residence in Baltimore: No. 714 Forrest St. St.; ....yrs,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ...July.... (Month) Not Known (Day), 1881 (Year)

7-AGE, ...36....yrs....4....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER, John Hannan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Connor

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Estella

(Address) 714 Forrest St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Nov.... (Month) ....15.... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12. 1917, to Nov. 14. 1917, that I saw him alive on Nov. 14. 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis of the Heart

(b) Uremia (Duration) ....yrs....mos....3....ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia (Duration) ....yrs....mos....4....ds.

(Signed) ....M. D.

Nov. 15, 1917. (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
St Vincents	Nov 16, 191...
20-UNDERTAKER	ADDRESS
C J Manning	1338 E Lafayette

S

D10112 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130 D10112

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 Druid [illegible] St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Priscilla Grubbs

(Residence in Baltimore: No. 1117 Druid [illegible] St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070

8 17

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Brown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Mary Boulon

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mark Brown

(Address) 1117 Druid Hill St.

15.

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Edward Smith M. D.
(Coroner)

11/16, 191.. (Address) 110 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Zion Cem.	Nov 16, 1917.
20-UNDERTAKER John H Owens	ADDRESS 8-23 Lib St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10113 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10113

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2018 Boyd St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella May Hook

(Residence in Baltimore: No. 2018 Boyd St St.; 1 yrs., 11 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White.	Single

6-DATE OF BIRTH, November 24, 1915
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel J. Hook

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Maggie Kenney

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Hook

(Address) 2018 E Boyd St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 14 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-9 1917, to 11-13 1917, that I saw h[illegible] alive on 11-13 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

over

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ....yrs. ....mos. ....ds.

(Signed) Harry Goldberg M. D.

11-16, 1917. (Address) 2231 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cemetery	Nov. 16th, 1917.
20-UNDERTAKER	**ADDRESS**
George R. Pelrose & Bro	2101 Pennsylvania Ave

NOV 16 1917

9

Spec.—8-24-14—M. & T.—2000 Bks.

D10111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10111

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2620 Freemont Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alphonso Joseph McLaughlin

(Residence in Baltimore: No. 2620 Freemont Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, December 28th, 1911
(Month) (Day) (Year)

7-AGE, 5 yrs. 10 mos. 18 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Francis McLaughlin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaretta Herzog

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis McLaughlin

(Address) 2620 Freemont Ave.

15-

Filed....., 191.....

Registrar.

over

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1917, to Nov 15th 1917, that I saw h.. alive on Nov 15th 1917, and that death occurred, on the date stated above, at 36 m.

The CAUSE OF DEATH* was as follows: Thrombosis Lateral Sinus

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Suppurative Otitis Media

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) ..... M. D.

Nov 15th, 1917. (Address) 437 Freemont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Nov 17, 1917
20-UNDERTAKER	ADDRESS
E. J. Wiedefeld	Freemont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10115

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D10115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 342 S Calhoun ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary K Hunter

(Residence in Baltimore: No. 342 S Calhoun St.; ....yrs., 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, ... May (Month) 22 (Day), 1915 (Year)

7-AGE, ... 1 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md Walker Min

PARENTS.

10-NAME OF FATHER, Frederick Hunter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emma Heer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Hunter

(Address) 342 S. Calhoun St

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1917, to Nov 14 1917, that I saw h[illegible] alive on Nov 14 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis

..... (Duration) ....yrs. ....mos. 4 days.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Jno A. Cole M. D.

1116, 191.. (Address) 341 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wesley	Nov 17, 1917.
20-UNDERTAKER	ADDRESS
J Thos J Field	1200 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10116

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor 79 REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Heinrich Gottlieb Reinder

(Residence in Baltimore: No. ..... St.: .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Wid.

6-DATE OF BIRTH, ... Aug. (Month) ..... 2 (Day), 1837 (Year).

7-AGE, 80 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Freidrich Reinder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Frank

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

NOV 16 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191, to ..... 191, that I saw h[illegible] alive on Nov 11 191 7, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Asthma

Unknown (Duration) ....yrs....mos....ds.

(Signed) F. A. Barnes M. D.

Nov 16, 1917. (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 10 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Nov. 19, 1917.
20-UNDERTAKER Wendell Dippel	ADDRESS 37 S. Ann St

D1017

HEALTH DEPARTMENT—CITY OF BALTIMORE

1PLACE OF DEATH

CERTIFICATE OF DEATH.

120 ✓

REGISTERED No. C D1017

CITY OF BALTIMORE (No. 222 Bowers ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie ~~Jackson~~ Jackson

(Residence in Baltimore: No. 222 Bowers St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept (Month) 16 (Day), 1901 (Year)

7-AGE,	If LESS than 1 day,
16 yrs. 1 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): in service

87

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Jackson

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER Annie Minor

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jamie Queen

(Address) 531 Colonial St

15-

Filed....., 191.....

Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows)

Chronic Nephritis

(Duration).....yrs. 5 mos.....ds.

CONTRIBUTORY (Secondary) Gradual Dilation of heart

(Duration) 1 yrs. 1 mos.....ds.

(Signed) James McPherson (Coroner.) M. D.

Nov 14 1917 (Address) 7 W E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 17 1917
20-UNDERTAKER Brown & Ireland	ADDRESS 114 N. Gilmor St.

Spec.—8-24-14—M. & T.—2000 Blks.

D10118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10118

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Slentz (Slentz)

(Residence in Baltimore: No. 506 S. Ellwood Ave. St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 31, 1867
(Month) (Day) (Year)

7-AGE, 48 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: American Can Co
(b) General nature of industry, business, or establishment in which employed (or employer): 4086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wm. Slentz

11-BIRTHPLACE OF FATHER (State or Country), Prussia

12-MAIDEN NAME OF MOTHER Elizabeth Colley

13-BIRTHPLACE OF MOTHER (State or Country), Prussia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) [illegible]

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1917, to Nov. 15 1917, that I saw h.m alive on Nov. 15 1917, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) yrs. mos. ds.

(Signed) Edward H. Smith M. D.

11/16, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 16 ds. In the State 2 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 506 S. Ellwood Ave

Former or usual residence 506 S. Ellwood Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Waynesboro, Pa.	Nov. 17, 1917
20-UNDERTAKER	ADDRESS
Zinkand & Zinkand	1739 E. Eager

Spec.—8-24-14—M. & T.—2000 Bks.

D10119 D10119

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2083 Frederick Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Brautigan

(Residence in Baltimore: No. 2583 Frederick Ave St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July 13th (Month) (Day), 1835 (Year)

7-AGE, 82 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... DHS

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Adam Brautigan

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Trebes

(Address) 2583 Fredrick ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 15 1917, to Nov 15 1917, that I saw him alive on Nov 14 1917, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) Asa L Wessels M. D.

Nov 16, 1917 (Address) 2565 Frederick ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov 16, 1917

20-UNDERTAKER 6th McCormick

ADDRESS 1321 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10120

CERTIFICATE OF DEATH.

81

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2531 Guilford Av WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Duffy

(Residence in Baltimore: No. 1014 N Wallace St- St.: 64 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, June 21, 1853
(Month) (Day) (Year)

7-AGE, 64 yrs. 4 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Duffy

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Ellen Sherry

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Clarke

(Address) 2531 Guilford Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-18 1917, to 11-14 1917, that I saw h alive on 11-14 1917, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) yrs. mos. ds.

(Signed) W Bernardine M. D.

11-15, 191... (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Grounds. DATE OF BURIAL, Nov. 17, 1917

20-UNDERTAKER H. C. Wedefeld ADDRESS 914 E Lanvale St

Spec.—8-24-14—M. & T.—2000 Bks.

D10121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D10121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1652 Dulaney (St.:) 20 (Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip D. Copeland

(Residence in Baltimore: No.) 1652 Dulaney St.: 49 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct. 11, 1839
(Month) (Day) (Year)

7-AGE, 78 yrs. 1 mos. ✓ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 016
(b) General nature of industry, business, or establishment in which employed (or employer): Building Contractor

9-BIRTHPLACE, (State or Country), London Co Va

PARENTS.

10-NAME OF FATHER, John Copeland.

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Delilah Courtney

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Rosa Copeland

(Address) 1652 Dulaney St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 14 1917, to Nov 15 1917, that I saw him alive on Nov 14 1917. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. 6 mos. ds.

(Signed) Asa L Wessels M. D.

Nov 15, 1917 (Address) 2565 Fred Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Nov. 16, 1917

20-UNDERTAKER Jos F & R Cook

ADDRESS 1003 N. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D10122

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

113

D10122

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 E Baltimore ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. May

(Residence in Baltimore: No. 2500 E. Baltimore St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Aug. (Month) 30 (Day), 1843 (Year)

7-AGE, 69 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soda Mfg.
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 04

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August H. May

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Maria Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa May

(Address) 2500 E Baltimore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 15 1917, that I saw him alive on Nov 15 1917, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Indefinite. yrs. mos. ds.

(Signed) E. Oliver Murray M. D.

Nov 16, 191... (Address) 1224 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Nov. 18, 1917.
20-UNDERTAKER	**ADDRESS**
Christian Miller	2534 Jefferson

NOV 16 1917 ROBERT R. KRAUTER REGISTRAR

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10123

CERTIFICATE OF DEATH.

64 D10123

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 W Pratt ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Whelan

(Residence in Baltimore: No. 1422 W Pratt St.; 57 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE~~ MARRIED, ~~WIDOWED OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, Sept 4 (Month), ... (Day), 1843 (Year)

7-AGE, 74 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Cornelius Healy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Nancy Short

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs K Whalen

(Address) 1422 W Pratt St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Nov 15 1917, that I saw h..... alive on ..... 191..., and that death occurred, on the date stated above, at 7.25 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) M O'Donnell M. D.

Nov 16 191.7. (Address) 108 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cathedral Cemetery DATE OF BURIAL, Nov 17 191 7

20-UNDERTAKER Geo A Kerby ADDRESS Back & Payson

Spec.—5-19-13—M. & T.—500 Bks.

10121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 10121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Sargent St. ST.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Holzwarth

(Residence in Baltimore: No. 1208 Sargent St. St.; 10 yrs, mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Nov. 26, 1884
(Month) (Day) (Year)

7-AGE, 32 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

9-BIRTHPLACE, (State or Country) Russia

PARENTS.

10-NAME OF FATHER, John Schmick

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Marie Shuruaun

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Holzwarth

(Address) 1208 Sargeant St

15-

Filed ....., 191.... Registrar.

NOV 16 1917

ROBERT E. KRUG
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11 1917, to Nov. 16 1917, that I saw h.. alive on Nov. 15 1917, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Acute tuberculous laryngitis

(Duration) ....yrs. ....mos. 6 ds.

(Signed) Chas. T. Seabury M. D.

Nov. 16, 1917. (Address) 621 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov. 19, 1917

20-UNDERTAKER Joseph B Cook ADDRESS 1003 W. Baltimore St.

D10125

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10125

REGISTERED No. C 67

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 606 S. Paca St.: [illegible] WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maggie Stewart.

(Residence in Baltimore: No. Life - 606 S Paca St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH September — (Month), 1850 (Day) (Year)

7 AGE 67 yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): — 037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frederick Bloss

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ebenezer Stewart

(Address) 606 S Paca St

15 Filed — , 191 — REGISTRAR

NOV 16 1917 ROBERT R. KRAUTZ
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. (Month) 14 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 , 1917 , to Nov. 14, 1917.
that I saw h[illegible] alive on Nov. 14 , 1917.
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Paresis (Cause unk)

6020

(Duration) — yrs. 11 mos. — ds

Contributory (SECONDARY) Paralysis of left side.

(Duration) — yrs. — mos. 2 ds.

(Signed) Annat S. Chambers M. D.

Nov. 15, 1917 (Address) 1017 N. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 17, 1917

20 UNDERTAKER: Wm Pickmer & Son — ADDRESS: Pennsylvania Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D10126

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 887 Hollins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Cowan

(Residence in Baltimore: No. 887 Hollins St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, November 15, 1857.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
60 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Work

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Edward Cowan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Clary

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Bernberg

(Address) 34 Parkin St.

15-

Filed ....., 191...

Registrar.

NOV 17 1917 ROBERT B. KNAUTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1917, to Nov 15 1917, that I saw her alive on Nov. 15 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Bernard J. Farry M. D.

, 191... (Address) 889 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 38 yrs. mos. ds. In the State 60 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 887 Hollins St

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. | DATE OF BURIAL, Nov 19, 191.

20-UNDERTAKER John Cowan & Son | ADDRESS 901 Hollins St

D1012 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 151 D1012

1PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED No. C

CITY OF BALTIMORE (No. 7 ½ Bethel St St. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Duda

(Residence in Baltimore: No. 7 ½ Bethel St St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	single

6-DATE OF BIRTH, Nov (Month) 16 (Day), 1917 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 3 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

630

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Julian Duda

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER Stella Defonska

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joel Fredowski

(Address) 728 S. Bond st.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital debility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otis Wyatt Smith (Coroner.) ..... M. D.

Nov 17, 1917. (Address) 210 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Holy Rosary

DATE OF BURIAL, Nov 17, 19 17

20-UNDERTAKER Jacob Fialkowski

ADDRESS 728 S. Bond St

Important. See instructions on back of certificate.

NOV 17 1917 ROBERT B. KRAUTER Burial Permit Clerk

D10128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10128

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 837 Parrish alley St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Brown

(Residence in Baltimore: No. 837 Parrish alley St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Unknown, 1876
(Month) (Day) (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE. (State or Country), Frederick Co

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Miles

(Address) 1009 N Parrish

15-

Filed....., 191.....

C. S. P. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

(a) Chronic Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. ds.

(Signed) F. E. Smith M. D.
(Coroner)

11/16, 1917. (Address) 910 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 17, 1917
20-UNDERTAKER	ADDRESS
Sam'l Case Son	1400 McCulloh

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10129

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Maine Ave, Forest Park ST.: 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Delano Benton.

(Residence in Baltimore: No. 3925 Maine Ave. Forest Park St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, December 10th, 1857
(Month) (Day) (Year)

7-AGE, 59 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: tin worker
(b) General nature of industry, business, or establishment in which employed (or employer): Tin Decorating Co.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Samuel Benton

11-BIRTHPLACE OF FATHER (State or Country) Alexandria, Va.

12-MAIDEN NAME OF MOTHER Annie Eliza Curry

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. H. Burns

(Address) 3925 Maine Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 1917, to Nov 16 1917, that I saw h-me alive on Nov. 15 1917, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Lewis McKenna Jr. M. D.

Nov. 16, 1917. (Address) 1505 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov 19, 191...

20-UNDERTAKER H E Hughes — ADDRESS 5 Broadway

C. S. P.

Spec.—8-24-14—M. & T.—2000 Bks.

D10130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D10130

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 E. Washington ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Henry Erdman

(Residence in Baltimore: No. 316 E. Washington St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, October (Month) 4 (Day), 1843 (Year)

7-AGE, 74 yrs. 1 mos. 10 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Erdman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Dorothy Mather

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dorothy Knightson daughter

(Address) 316 E. Washington St.

15-

Filed....., 191.....

C. S. C. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 14th (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1913, to Nov. 14 1917, that I saw him alive on Nov. 14 1917, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Geo. Heller M. D.

11-16, 1917 (Address) 1137 York St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery | DATE OF BURIAL, Nov 17, 1917

20-UNDERTAKER H. E. Hughes | ADDRESS 17 S. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Elm Place ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith May Dobson

(Residence in Baltimore: No. 920 Elm Place St.; — yrs., 2 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug. (Month) 21 (Day), 1914 (Year)

7-AGE, ...yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Dobson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Martha Charms

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Charms Dobson

(Address) 920 Elm Place

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1917, to Nov 17 1917, that I saw her alive on Nov 16 1917, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Asthenia

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) William E Burton M. D.

Nov 17, 1917. (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Glyndon Md

DATE OF BURIAL, Nov. 17, 1917.

20-UNDERTAKER Wood Earlom

ADDRESS 916 Penna ave

Mar 1991-5

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 110132

CERTIFICATE OF DEATH.

16 110132

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Redford Brent

(Residence in Baltimore: No. 206 S Gilmor St

St.: yrs, — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, [redacted] 10, 1897
(Month) (Day) (Year)

7-AGE. 19 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper in forge shop
(b) General nature of industry, business, or establishment in which employed (or employer): B. Hayward Co.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John J. Brent.

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Bettie R. Kent

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Brent

(Address) Nelson Co Va

15-

NOV 15 1917

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lineal Pneumonia

36 24 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) W. A. Riley M. D.
(Coroner.)

Nov 17, 191.. (Address) 1029 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 36 hrs mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Tye River Nelson Co Va

DATE OF BURIAL, Nov 20, 19..

20-UNDERTAKER George J. Smith

ADDRESS 900 N Gilmor

NOV 17 1917

Important. See instructions on back of certificate.

D10132

HEALTH DEPARTMENT—CITY OF BALTIMORE

172 ✓ D10133

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Karl Wehrum

(Residence in Baltimore: No. 1416 S. Charles St. 3 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, about (Month) (Day) 1872 (Year)

7-AGE, about 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Graham

(Address) 1416 S. Charles St.

15-

Filed ....., 191....

Registrar.

NOV 17 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of Skull

3 days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fell Down Steps

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Kelly (Coroner.) M. D.

....., 191... (Address) 1627 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1416 S. Charles St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Marietta Ohio	Nov. 15., 19.17
20-UNDERTAKER	ADDRESS
Mrs E. E. Evans Sons	1422 E. Chas St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10131 D10131

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 Worsley St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Stevens

(Residence in Baltimore: No. 320 Worsley St. St.; X yrs., 8 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) ..... (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9-BIRTHPLACE, (State or Country), Eston Shore Md

PARENTS.

10-NAME OF FATHER. Joseph Paul

11-BIRTHPLACE OF FATHER (State or Country), Eston Shore Md

12-MAIDEN NAME OF MOTHER Ellen Brown

13-BIRTHPLACE OF MOTHER (State or Country), Eston Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) her Son Solmon R Cain

(Address) 320 Worsley St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14th 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1917, to Nov 15 1917, that I saw h[illegible] alive on Nov 14 1917, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

1 Broken Decompensation
2 Arteriosclerosis
3 Chronic Kidney trouble

(Duration) 1 yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Not given

(Duration) ? yrs. ? mos. ? ds.

(Signed) Dr. Geo L Will M. D.

Nov 15, 1917. (Address) 1628 Dunbar Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Novem. 18., 1917.

20-UNDERTAKER Mrs R A Elliott — ADDRESS 404 East St

Mad 3149-8.

Spec.—8-24-14—M. & T.—2000 Bks.

D10135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+120 D10135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alex Rondau

(Residence in Baltimore: No. 101 Elen St. Curtis Bay St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown, 1881
(Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, G Roman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Amelia —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jr. Salan M.D.

(Address) University Hospital

15-

Filed ....., 191.....

Registrar.

NOV 18 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/9 1917, to 11/17 1917, that I saw h Lm alive on 11/17 191 7, and that death occurred, on the date stated above, at 7 20 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis

(Duration) yrs. 3 mos. ds.

(Signed) [illegible] M. D.

11/17, 191 7 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 8 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Balto Md

Former or usual residence 101 Elen St.

19-PLACE OF BURIAL OR REMOVAL: Holy Cross 4460 — DATE OF BURIAL, Nov 20, 191 7

20-UNDERTAKER John Gobbleman — ADDRESS 945 S Conk St

Spec.—8-24-14—M. & T.—2000 Bks.

D10136 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 E. Bernard ST.: 12 WARD) REGISTERED NO. C

2-FULL NAME Maggie Lowe

(Residence in Baltimore: No. 2629 E. Bernard st. St.) 34 yrs., 7 mos. 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Married

6-DATE OF BIRTH, April 10, 1883.
(Month) (Day) (Year)

7-AGE, 34 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): Rathmell

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William C. Bowman

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Fannie E. Grant

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Meyer

(Address) 4705 Eastern Ave

15-

Filed....., 191.....
Registrar.

NOV 18 1917 ROBT. C. ARTHURS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1917, to Nov 17 1917, that I saw h[illegible] alive on Nov 16 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus (cause) 1 y

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emil Novak M. D.

Nov 18, 191... (Address) 26 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Harper Cemetery	Nov. 20, 191..
20-UNDERTAKER	ADDRESS
Leonard Lohr	541 Fountain Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10137 104 ✓ D10137

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 W. 37th. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret W. Jackson

(Residence in Baltimore: No. 906 W. 37th. St.; — yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan (Month) 12th. (Day), 1917. (Year)

7-AGE, ... yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 001

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, Richard T. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Balt Md

12-MAIDEN NAME OF MOTHER Edith May Peck

13-BIRTHPLACE OF MOTHER (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thurs W. Jackson

(Address) 906 W. 37th St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18th 191 7, to Nov 16th 191 7, that I saw h[illegible] alive on Nov 16th 191 7, and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

..... Broncho Pneumonia

..... (Duration) ..... 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Infantile Paralysis

..... (Duration) ..... 17 yrs. ..... 2 mos. ..... ds.

(Signed) ..... B. A. Lillich M. D.

Nov 16, 191 7 (Address) 1127 Mosher Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, Nov 17, 191 7

20-UNDERTAKER Saunders & Son — ADDRESS 2617 Eastern Ave

NOV 18 1917

D10135 D10135

HEALTH DEPARTMENT—CITY OF BALTIMORE

1718 E Fayette St 186

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. City Morgue ST.: 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Steadleman

(Residence in Baltimore: No. 1718 E. Fayette St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 32 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levis

(Address) 1411 E Baltd St

15-

Filed NOV 18 1917, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abortion Criminal

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Friedenwald M. D.
(Coroner)

Nov 15, 191... (Address) 1411 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel DATE OF BURIAL, 11/18, 191.7

20-UNDERTAKER Jack Levis ADDRESS 1411 E Balto St

important. See instructions on back of certificate.

D10139

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10139

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REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Ashburton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Bond

(Residence in Baltimore: No. 1629 Ashburton St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male.

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb. (Month) 22, (Day) 1862 (Year)

7-AGE: 55 yrs. 8 mos. 15 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

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9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Emanuel Bond.

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bond

(Address) 1629 Ashburton

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Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan., 1916, to Nov. 1917, that I saw him alive on Nov. 16 1917, and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver (Duration) 4 yrs mos ds.

Contributory (SECONDARY) Stomach cancer (Duration) yrs mos. 2 ds.

(Signed) H. C. Kelam M. D.

Nov 16, 1917 [Address] 2757 Wyoming

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Nov 19, 1917

20-UNDERTAKER: William Cook — ADDRESS: 502 E. North ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D10140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10140

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Smallwood ST.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph. A Herr.

(Residence in Baltimore: No. 1728 Smallwood St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 5., 1878
(Month) (Day) (Year)

7-AGE, 39 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Leabolt Herr.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Kuhl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Herr

(Address) 1728 Smallwood St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1916, to Nov. 16 1917., that I saw h im alive on Nov. 16 1917., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of kidney (left side) Had kidney removed April 22 1916 - seemed better until 2 months ago the other kidney showed involvement. No cough has had the last two weeks (Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 2 ds.

(Signed) Chas H Bubert M. D.

Nov. 17., 191.7. (Address) 1100 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Nov. 19..., 191.7.

20-UNDERTAKER Wallace Cook ADDRESS 602 E Nathan

Dr Chas H Bubert 1100 W Lafayette Ave

D10141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10141

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1709 Pierce ST. 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Comegys

(Residence in Baltimore: No. 1709 Piece St. ~~yrs., mos. ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..X.. (Month) Unknown (Day), 1 (Year)

7-AGE, ..30.. yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): at home 041

8th

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Brown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER X Unknown

13-BIRTHPLACE OF MOTHER X Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X William Brown

(Address) 1709 Piece st.

15-

Filed ....., 191.....

Registrar.

Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy of inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OR DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of aroma of Sudden Artery

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Purdon M. D.
(Coroner.)

Nov. 16 1917 (Address) 700 E Chase st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 18, 1917

20-UNDERTAKER Bromwell Freeland & Schubert

ADDRESS 114 N. ...

Spec.—8-24-14—M. & T.—2000 Bks.

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HEALTH DEPARTMENT—CITY OF BALTIMORE

D10142

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH University Hospital REGISTERED NO. C.....

CITY OF BALTIMORE. (No. ..... ST.; W WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward R. Sprinkel

(Residence in Baltimore: No. 526 Portland St.; ~ yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... September ....., 1887.
(Month) (Day) (Year)

7-AGE, 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
63 (b) General nature of industry, business, or establishment in which employed (or employer) Riveter 086

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella V. Sprinkel

(Address) 526 Portland St

15-

Filed ....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 11 (Month) ..... 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/15 1917, to 11/15 1917, that I saw him alive on 11/15 1917, and that death occurred, on the date stated above, at 10:58 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis

Transpleurisy

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute nasopharyngitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11/15, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. 3 mos. ..... ds.

Where was disease contracted, if not at place of death? Balto Md

Former or usual residence 526 Portland St.

19-PLACE OF BURIAL OR REMOVAL, Dorsey Md. DATE OF BURIAL, Nov. 19., 1917.

20-UNDERTAKER Alfred C. Fuller ADDRESS 221 N Bond

D10142

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

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D10142

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1222 Oakhurst Place 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bernard Deters

(Residence in Baltimore: No. 1222 Oakhurst Place St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: August (Month) 11 (Day), 1917 (Year)

7-AGE: yrs. 3 mos. 6 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: John Bernard Deters

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Jane Nowell

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Bernard Deters

(Address) 1222 Oakhurst Pl.

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 29, 191 7, to, Nov 17 1917, that I saw h[illegible] alive on Nov 14th 1917, and that death occurred, on the date stated above, at 6: a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs mos. 3 ds.

Contributory (SECONDARY) Congenital foramen ovale (Duration) yrs 3 mos. 6 ds.

(Signed), E E Dugan M. D.

Nov. 17 191 7 [Address] 301 E Cross St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Ala

DATE OF BURIAL: Nov. 19 191 7

20-UNDERTAKER: E & B Hake

ADDRESS: 115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D10141

CERTIFICATE OF DEATH.

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1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.; W WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludinka Helmenski

(Residence in Baltimore: No. 516 E. Washington St St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknow (Month) (Day), 1863 (Year)

7-AGE, 54 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Helminski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Alberta Wolgend

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sadowski

(Address) 1735 Brant St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Nov. 17 1917, that I saw h alive on Nov. 17, 1917, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated femoral hernia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) J. A. Dawden M. D.

Nov. 17, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 516 E. Washington St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Nov 19, 1917.

20-UNDERTAKER	ADDRESS
W. F. Sadowski	705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

D10145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

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REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 E. Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. White

(Residence in Baltimore: No. 2441 E. Jefferson St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March 14, 1860
(Month) (Day) (Year)

7-AGE, 57 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mason
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

27 090

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian W. Miller

(Address) 2334 Jefferson St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Nov 14 1917, that I saw him alive on 11/14 1917, and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. C. Keating M. D.

11/15, 1917. (Address) 2600 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Nov 18, 1917
20-UNDERTAKER	ADDRESS
Christian Miller	2334 Jefferson St

D10146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10146

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 541 Mowher St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Lee Hall

(Residence in Baltimore: No. 541 Mowher St

St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1879
(Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. John Hall

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Sowell

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hall

(Address) 541 Mowher St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Loscale M. D.
(Coroner)

Nov. 17, 191.7 (Address) 1211 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion

DATE OF BURIAL, Nov. 18, 1917

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

D1017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1017

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Jane

(Residence in Baltimore: No. 1425 N Vincent St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, ... (Month) 14 (Day) 1875 (Year)

7-AGE, 42 yrs. 9 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Factory
(b) General nature of industry, business, or establishment in which employed (or employer) "

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Sterling Tyson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records

(Address) Mercy Hosp

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 191 , to Nov. 18 191 , that I saw h[illegible] alive on [illegible] 191 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .....yrs. mos. 10 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Edwin M. Smith M. D.

....., 191... (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1425 Vincent St.

Former or usual residence 1425 Vincent St.

19-PLACE OF BURIAL OR REMOVAL, St. Alphonsus, Woodstock

DATE OF BURIAL, Nov. 20, 1917

20-UNDERTAKER Euston's Sons

ADDRESS Ellicott City

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D1014S 104 D1014S

REGISTERED NO. C

1-PLACE OF DEATH Strong Apartments

CITY OF BALTIMORE (No. Linden Ave & Chauncey Av ST.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alma Kernfood

(Residence in Baltimore: No. Linden Ave & Chauncey Av St.: yrs. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Nov 4, 1917 (Month) (Day) (Year)

7-AGE: yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 4 000

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Allen A Kernfood

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Myrtle Folk

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen A Kernfood

(Address) Linden & Chauncey Av

15-

Filed NOV 18 1917, 191 HARRY C. ANDREWS Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 18 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4, 191 , to Nov. 18, 191 ,

that I saw h alive on Nov. 18, 191 ,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

Convulsions

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. 5 ds.

(Signed) J. Abelman M. D.

Nov 18, 1917 (Address) 1720 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Nov 18, 1917

20-UNDERTAKER: Jackson — ADDRESS: 16 W Mad

is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10149 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10149

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N Ostend St. ST.; 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella F. Harrigan

(Residence in Baltimore: No. 140 N Ostend St. St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 53 ....., ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housework

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Gregor Brannan

11-BIRTHPLACE OF FATHER (State or Country), Washington DC

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Harrigan

(Address) 140 N. Ostend St

15-

NOV 18 1917 MARY C. ANDREWS

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 16 ....., 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1917, to Nov 16 1917, that I saw h[er] alive on Nov 16 1917, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma Pancreas

2. .....

(Duration) ...yrs. 8 mos. ...ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

(Duration) ...yrs. 6 mos. ...ds.

(Signed) Jas F O'Donnell M. D.

Nov 16, 191... (Address) 1021 E Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cemetery Wash. D.C.

DATE OF BURIAL. Nov 19th, 1917

20-UNDERTAKER M. J. F. Lynn

ADDRESS 1422 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10150 D10150

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bella Kraus

(Residence in Baltimore: No. 2019 Madison Av. St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... Unknown ..... (Month), ... (Day), 18.8 (Year)

7-AGE, 49 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... J. Lewis .....

(Address) ..... 1411 E. Balto .....

15-

NOV 13 1917 HARRY C. ANDREWS

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 16. (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Nov. 16 1917, that I saw h.. alive on Nov. 16 1917, and that death occurred, on the date stated above, at 4.55 p.m.

The CAUSE OF DEATH* was as follows:

..... Thrombosis .....

..... (Duration) ..... yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstit. Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Edward E. Brush ..... M. D.

....., 191... (Address) ..... Mercy .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 12 ds. In the State 25 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 2019 Madison Av

19-PLACE OF BURIAL OR REMOVAL, Balt Hebrew Cem

DATE OF BURIAL, 11.18., 1917

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D10151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10151

CERTIFICATE OF DEATH.

103

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Gorsuch Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Bauer

(Residence in Baltimore: No. 808 Gorsuch Ave. St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sing[le]

6-DATE OF BIRTH, Nov 8, (Month) (Day), 1879 (Year)

7-AGE, 38 yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hall Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): 052

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John A Bauer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna C Wahrenbrock

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard E Bauer

(Address) 808 Gorsuch Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 16, (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 16 1917, to Mar 16 1917, that I saw h[im] alive on Mar 16 1917, and that death occurred, on the date stated above, at 6:10 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 2 hours

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) Indefinite

(Signed) H Russell Lee M. D.

3/16, 1917. (Address) 231 N Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, Mar 19, 1917

20-UNDERTAKER Robert J Turner — ADDRESS 1714 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D16152

HEALTH DEPARTMENT—CITY OF BALTIMORE

Harper ✓

D16152

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Ridgewood ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Edwin Dilphia Waltz

(Residence in Baltimore: No. 2105 Ridgewood ave St.; 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 28 (Month) (Day), 1835 (Year)

7-AGE, 81 yrs. 10 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Oil
(b) General nature of industry, business, or establishment in which employed (or employer) Commission Merchant

9-BIRTHPLACE, (State or Country) Frederick Co. Md

PARENTS.

10-NAME OF FATHER, Isaac Waltz

11-BIRTHPLACE OF FATHER (State or Country) Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country) Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie J. Waltz

(Address) 2105 Ridgewood

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25 1917, to Nov 16 1917, that I saw h[illegible] alive on Nov 16 1917, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Arteriosclerosis

..... (Duration) yrs. 6 mos. 21 ds.

CONTRIBUTORY (Secondary) Chronic Intest. Nephritis

..... (Duration) yrs. 3 mos. ..... ds.

(Signed) J. L. Straus M. D.

Nov 18, 191... (Address) 912 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mount Olivet

DATE OF BURIAL. Nov. 19, 1917

20-UNDERTAKER Geo. Weber & Son 2503

ADDRESS Edmondson ave

Spec.—8-24-14—M. & T.—2000 Blks.

D10153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D10153

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Needham (Needham)

(Residence in Baltimore: No. 120 Mosher St ST.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Needham

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1517 Bolton St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 191 7 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 191 7, to Nov 17 191 7, that I saw him alive on Nov 17 191 7, and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Don't Know (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Not Ascertained

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Edward A Smith M. D.

Nov 17, 191 7 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 3 mos. — ds. In the State 50 yrs — mos. ds.

Where was disease contracted, if not at place of death? 120 Mosher St

Former or usual residence 120 Mosher St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 19, 191 7

20-UNDERTAKER Martin Feeley & Son

ADDRESS 606 Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 11051 — 11051

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Comet ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence M. Paesch

(Residence in Baltimore: No. 1122 Comet St. St.; ..... yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Sept 18, 1915 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John Paesch

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Clara Garretson

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Paesch

(Address) 1122 Comet St.

15- NOV 19 1917

Filed ....., 191.....

Registrar.

W 4121

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-15 1917, to 11-16 1917, that I saw h[er] alive on 11-16 1917, and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Primary
..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Arthemia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Solomon C. Katz M. D.

11-17, 191 7. (Address) 111 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel — DATE OF BURIAL, Nov 19, 191 7

20-UNDERTAKER: Philip Herring — ADDRESS 20 E Oliver

Spec.—8-24-14—M. & T.—2000 Bks.

D10155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10155

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 N. Patterson Pk. Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Falck

(Residence in Baltimore: No. 135 N. Patterson Pk Ave St.; 58 yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... Jan (Month) 5 (Day), 1859 (Year)

7-AGE, 58 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Conrad Falck

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry F. Schutte

(Address) 135 N. Pat. Pk. Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 15th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29 1917, to Nov 15 1917, that I saw her alive on 11 14 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration).....yrs.....mos. 18 ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) A. A. Heaps M. D.

Nov 16, 1917. (Address) 2600 Eba Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cem. DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

N 6157-8.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D16156 D16156

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 940 S. Kenwood Ave St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Waters

(Residence in Baltimore: No. 940 S. Kenwood Ave St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Apr 15, 1835
(Month) (Day) (Year)

7-AGE, 82 yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Recently Retired before

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Waters

11-BIRTHPLACE OF FATHER (State or Country) England Maryland

12-MAIDEN NAME OF MOTHER Rachel Chaney

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Caroline Smith

(Address) 940 S. Kenwood

15-

NOV 10 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 16, 1917.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Nov 16 1917, that I saw h m alive on Nov 15 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis

abt 6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. abt 1 mos. ds.

(Signed) Leo Kaminsky M. D.

Nov 16, 1917 (Address) 1035 A. Dorman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER H. Sander Sons

ADDRESS 1710 Fleet St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10157

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10157

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 N. Hollins ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen V. Crawford

(Residence in Baltimore: No. 1913 N. Hollins St.; 1 yrs., 1 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September 30, 1916.
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry E. Crawford

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER, Mary A Williams

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry E. Crawford

(Address) 1913 Hollins St

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Filed....., 191.....

Registrar.

NOV 1917
ROBERT B. STARETT
REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1917, to Nov. 17 1917, that I saw her alive on Nov 17 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration)....yrs....mos. 9 ds.

CONTRIBUTORY (Secondary) Measles

(Duration)....yrs....mos. 7 ds.

(Signed) J. H. Phillips M. D.

....., 191... (Address) 1701 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, 11-19.., 1917

20-UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

D1015S

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D1015S

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 136 East Dr ST.: 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pinkie Carter

(Residence in Baltimore: No. 136 East St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE. 38 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic work
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Joe Coleman

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis (Gangrenous)

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs....mos....ds.

(Signed) A. J. Parker M. D.

(Coroner)

Nov 17, 1917. (Address) 659 Penn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Nov. 19..., 19...

20-UNDERTAKER Felix B. Pepe

ADDRESS 1125 Mulberry

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10159 HEALTH DEPARTMENT—CITY OF BALTIMORE D10150

CERTIFICATE OF DEATH.

114

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Franklin Miller

(Residence in Baltimore: No. 1514 Bolton ST. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. 28, 1862 (Month) (Day) (Year)

7-AGE, 55 yrs. 1 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Professor
(b) General nature of industry, business, or establishment in which employed (or employer): Johns Hopkins Hospital

9-BIRTHPLACE, (State or Country), Iowa

PARENTS.

10-NAME OF FATHER, Francis Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louise Miller

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Kirk

(Address) Johns Hopkins Hospital

15-

Filed ..., 191... Registrar.

NOV 19 1917 ROBERT R. KRAUSE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1917, to Nov. 17 1917, that I saw h[illegible] alive on Nov. 17 1917, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows: Jaw Sloughing Jaw Wound, Cystic Duct Communicates Cholecystitis

(Duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Operation

(Duration) ... yrs. 1 mos. ... ds.

(Signed) C. E. Bruce M. D.

Nov. 17, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 22 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1514 Bolton Street

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Nov. 19th 1917.

20-UNDERTAKER Henry W. Jenkins & Sons Co. ADDRESS Orchard & McCulloh

Spec.—8-24-14—M. & T.—2000 Bks.

D10160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10160

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David K. Riley

(Residence in Baltimore: No. 629 N. Eden St. St.: 63 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. (Not known) ....., 1 .....
(Month) (Day) (Year)

7-AGE, 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) .....

14 011

9-BIRTHPLACE, (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER. Howard Riley

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER Jane Hamilton

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rose M. Riley

(Address) 629 N. Eden St.

15- 1

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9 1917, to Nov. 17 1917, that I saw him alive on Nov. 17 1917, and that death occurred, on the date stated above, at 2.05 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 9 yrs. ..... mos. ..... ds.

(Signed) Edward H. Smith M. D.

Nov 17, 1917. (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. 63 mos. ..... ds.

Where was disease contracted, if not at place of death? 629 N. Eden St.

Former or usual residence 629 N. Eden St.

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Nov. 19, 1917

20-UNDERTAKER Henry Hook Son ADDRESS 301 E. Eager St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10161 D10161

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 67 Taylor ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Colbert

(Residence in Baltimore: No. 67 Taylor St. St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE, 43 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Foreman 086
(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER William Colbert

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary O'Keefe

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Brown

(Address) 1308 West St.

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Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-31 1917, to 11-17 1917, that I saw h[illegible] alive on 11-17 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

11-18, 1917 (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER C. J. Windfeld Jr.

ADDRESS Broadway

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10162 120 D10162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (NO. 822 Edmondson Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry H. Schmincke

(Residence in Baltimore: No. 822 Edmondson Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 21 (Month) (Day), 1857 (Year)

7-AGE, 60 yrs. 4 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watch Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herman Schmincke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Endorf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma L. Schmincke

(Address) 822 Edmondson Ave

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Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 4 1917, to Nov 17 1917, that I saw h[illegible] alive on Nov 17 1917, and that death occurred, on the date stated above, at 3.P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. 6 mos. ....ds.

(Signed) Joseph T. Herring M. D.

Nov 18, 1917. (Address) 1412 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, Nov. 20, 1917

20-UNDERTAKER Mr. & Mrs. John W. Leufel

ADDRESS 801 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10163

CERTIFICATE OF DEATH.

89

D10163

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2014 Hunter St. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Master C B Lewis

(Residence in Baltimore: No. 2014 Hunter St. St.; X yrs., X mos., X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 13, 1917.
(Month) (Day) (Year)

7-AGE, X yrs. 3 mos. X ds.

If LESS than 1 day, X hrs. or X min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Luther Lewis

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Ada Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Texas

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father Luther Lewis

(Address) 2014 Hunter St.

15-

Filed ....., 191...
Registrar.

NOV 19 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20th 1917, to Nov 16 191?, that I saw h[illegible] alive on Nov 15 191?, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Inanition and Atelectasis
Bronchitis

X (Duration) X yrs. 3 mos. X ds.

CONTRIBUTORY (Secondary) Prem Birth

X (Duration) X yrs. 3 mos. X ds.

(Signed) Dr. Geo. L. Hall M. D.

11/17, 191... (Address) 628 Dolphin Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. 3 mos. ds. In the State X yrs. 3 mos. ds.

Where was disease contracted, if not at place of death? X

Former or usual residence X

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL, NOV 17 1917, 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10161 64 D10161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Fremont St.; 18 Ward) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Ledley

(Residence in Baltimore: No. 512 N. Fremont Ave St.; 52 yrs., 6 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 26 (Day), 1865 (Year)

7-AGE,	If LESS than 1 day,
52 yrs. 6 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirt Operator
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John C. Ledley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Rachel Pindell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston Weaver

(Address) 512 N. Fremont Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1917, to Nov 18 1917, that I saw h[illegible] alive on Nov 17 1917, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis

(Duration) About 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Russell M. D.

Nov. 18 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Western	Nov 20, 1917
20-UNDERTAKER	ADDRESS
Geo. W. Weber	531 N. Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Mary V. Badham.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10165

CERTIFICATE OF DEATH.

28 D10165

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. King Badham

(Residence in Baltimore: No. 1837 McCulloh St. St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 8 (Day) 1890 (Year)

7-AGE. 27 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Edenton N. C.

PARENTS.

10-NAME OF FATHER, Alfred King

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Nancy Higdon

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Nancy King

(Address) 1837 Mc Culloch St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Nov. 18 1917, that I saw her alive on Nov. 3 1917, and that death occurred, on the date stated above, at 9½ a. m.

The CAUSE OF DEATH* was as follows:

.....)

Pulmonary

tuberculosis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Cook Wilkins M. D.

Nov 18, 191.. (Address) 810 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Edenton N. C. DATE OF BURIAL, Nov 20 1917

20-UNDERTAKER George H. Holland ADDRESS 1631 E. Hay

D10166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186 D10166

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Henry J. Chenoweth

(Residence in Baltimore: No. 1905 Christian St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec (Month) 23 (Day), 1906 (Year)

7-AGE, 11 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. William W Chenoweth

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Anna K. Kahl

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm W Chenoweth

(Address 1905 Christian St.)

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Skull accidental supposed to be struck in play by Ice on Halloween Eve

(Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) local Meningitis

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) James M Kerr (Coroner.) M. D.

Nov 17, 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2d ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Not Known

Former or usual residence 1905 Christian St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cemetery	Nov. 19th, 1917

20-UNDERTAKER	ADDRESS
George L. Schmidt & Bro	2101 Frederick Ave

Fil 34
D10167

HEALTH DEPARTMENT—CITY OF BALTIMORE

X D10167

CERTIFICATE OF DEATH.

167

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St.: W WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wm. Walton Jr.

(Residence in Baltimore: No. 951 Madison Ave St.: —yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Jas. Walton

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Amy Eckhardt

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. Walton

(Address) 951 Madison Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Contributory Arterio Sclerosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
36 hours (Duration) yrs. mos. ds.

(Signed) W S Rehn M. D.
(Coroner)

Nov 19, 1917. (Address) 1659 Division

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death about 12 hrs. In the State 6 wks.
.....yrs.....mos.....ds. .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL, Nov. 19, 1917

20-UNDERTAKER John D. Mitchell ADDRESS Bowie, Md.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10168

CERTIFICATE OF DEATH.

92

D10168

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Foster Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Dever

(Residence in Baltimore: No. 2364 Foster ave. St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... Dec. (Month) 23 (Day) 19 (Year) 1850

7-AGE, 67 yrs. 10 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Robert Neil

11-BIRTHPLACE OF FATHER (State or Country), Ind.

12-MAIDEN NAME OF MOTHER Elizabeth Lee

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Richardson

(Address) 2304 Foster ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov 15 1917, that I saw her alive on Nov 15 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11/16, 191.7 (Address) 2701 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Nov 17, 191.7

20-UNDERTAKER John A. Doran — ADDRESS 300 E. Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 East St. St.; 5 WARD)

REGISTERED NO. C 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grazia Cacomo

(Residence in Baltimore: No. 321 East St St.; 1 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Single

6-DATE OF BIRTH. Nov (Month) 17 (Day), 1916 (Year)

7-AGE, 1 yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Cacomo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Angela Solomone

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Cacomo

(Address) 321 East St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 18 1917, that I saw her alive on Nov 18 1917, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) Luigi D. DiStefano M. D.

Nov 19 1917 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent — DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER, Frank Crocker & Son — ADDRESS 1906 E Monument

1 P.M.

Spec.—8-24-14—M. & T.—2000 Bks.

D10170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D10170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cadamczyk

(Residence in Baltimore: No. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Nov (Month) 18 (Day), 1917 (Year)

7-AGE, ...yrs. ...mos. 1 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank Cadamczyk

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Cunieda Twardowska

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Cadamczyk

(Address) 1226 S. Ellwood Ave

15-

Filed ..., 191...

Registrar.

NOV 19 1917 ROBERT N. KRAUTER Asst. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1918, to Nov 18 1917, that I saw him alive on Nov 18 1917, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Injuries sustained at birth

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Instructed Labor

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

Nov 18, 1917. (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? United States Hospital

Former or usual residence 1226 S. Ellwood Ave

19-PLACE OF BURIAL OR REMOVAL, St. Francis Xavier Cem

DATE OF BURIAL, Nov 19, 1917

20-UNDERTAKER Stephen J. Salvosti

ADDRESS 1011 Fleet St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

M10171 M10171

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 867 Linden ave. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Williams

(Residence in Baltimore: No. 867 Linden Ave St.; 0 yrs., 0 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, November (Month) 9 (Day), 1917 (Year).

7-AGE. 0 yrs. 0 mos. 9 ds.

If LESS than 1 day, 0 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Berry Mosby

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), Greensborough, Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Williams

(Address) 867 Linden Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November (Month) 18 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from November 9, 1917, to November 18, 1917, that I saw him alive on November 18, 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition due to an apparent lack of proper care

(Duration) 9 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

(Signed) C. H. Conner M. D.

Nov. 18, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Nov. 19, 1917.

20-UNDERTAKER Geo J. H. Locks ADDRESS 1302 Jefferson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10172 D10172

CERTIFICATE OF DEATH.

28

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Maryland Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Nelson Bundey Jr

(Residence in Baltimore: No. 1203 Maryland Ave St.; 32 yrs., 3 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 1st (Day), 1885 (Year)

7-AGE, 32 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chiropodist
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Dr R. H. Bundey.

11-BIRTHPLACE OF FATHER (State or Country), Essex Co Va.

12-MAIDEN NAME OF MOTHER Lillian Rick

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. R. H. Bundey

(Address) 1205 Md Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11th 1917, to Nov 16th 1917, that I saw him alive on Nov 15th 1917, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs. 15 mos.....ds.

(Signed) Harry K. Brown M. D.

Nov 16, 1917. (Address) 1501 Pressman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lyons Cemetery

DATE OF BURIAL, Nov 17, 191...

20-UNDERTAKER J. Wood & Co

ADDRESS 1317 Druid Pk

D10173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10173

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 107 E. Pleasant ST.: 4 WARD) REGISTERED NO. C

2-FULL NAME Sallie Potter

(Residence in Baltimore: No. 107 E. Pleasant

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid.

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, about 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Dont know

11-BIRTHPLACE OF FATHER (State or Country) Dont know

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Montgo

(Address) 17 E Pleasant St

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. disease heart

Contributory (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Daly (Coroner) ..... M. D.

Nov 18, 191 7. (Address) 16 E Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lane Cemetery DATE OF BURIAL, Nov 20, 191 7

20-UNDERTAKER J. H. Lee & Co ADDRESS 1017 Pa Ave

Important. See instructions on back of certificate.

NOV 13 1917 ROBERT R. KRAUTER

D10171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10171

166

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1105 Laurens St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosaile Baum

(Residence in Baltimore: No. 1105 Laurens St. St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 8, 1848
(Month) (Day) (Year)

7-AGE, 69 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Lewis

(Address)..... 1411 E Baltimore St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest by
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction
Due to Bed Confinement
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(Duration) yrs. mos. ds.

(Signed) F. Wolbarsht M. D.
(Coroner.)
Nov 19, 191.. (Address) 8 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bair Hebrew — DATE OF BURIAL, Nov. 19, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt St

NOV 19 1917 ROBERT E. KRAUTER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10175 D10175 120

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 N. Ellwood St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosella Phillips

(Residence in Baltimore: No. 208 N. Ellwood ave St.; [illegible] yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug 31, 1849 (Month) (Day) (Year)

7-AGE, 68 yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. E. Cullison

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary B. Hammer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Cullison

(Address) 3022 E. Fayette

15-

Filed....., 191.....

Registrar.

NOV 19 1917 ROBERT L. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1917, to Nov. 17 1917, that I saw h[illegible] alive on Nov. 17 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) yrs. 12 mos. ds.

(Signed) Geo. Fuller M. D.

11-19, 191.. (Address) 1937 Gough

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Nov 21, 1917.

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager

Spec.—5-19-13—M. & T.—500 Bks.

D10176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 ✓ D10176

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Warner St. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Klein

(Residence in Baltimore: No. 1203 Warner St. St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Feby. 7th, 1856 (Month) (Day) (Year)

7-AGE, 61 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Glass Blower
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

39

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Klein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Klein

(Address) 1203 Warner St

15-

Filed....., 191.....

NOV 19 1917 ROBERT H. EBAUGH Registrar.

Important. See instructions.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 18 1917, that I saw h— alive on Nov 18 1917, and that death occurred, on the date stated above, at 2 p m.

. The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(Duration) yrs. mos. 3w ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. ? mos. ds.

(Signed) Stephen A. Draper M. D.

Nov, 1917. (Address) 1217 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Nov. 21, 1917

20-UNDERTAKER C. Schumann Son ADDRESS 1034 Hanover St

Spec.—8-24-14—M. & T.—2000 Bks.

D10177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130 ✓ D10177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Kowacka

(Residence in Baltimore: No. 2126 Canton. ave St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, June (Month) 18 (Day), 1889. (Year)

7-AGE, 27 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Adolph Kowakalsky

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Victoria Kowakalsky

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) K. Libby

(Address) Johns Hopkins Hosp

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 18th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 18 1917, that I saw h[illegible] alive on Nov 18 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulsatans Uteri post operative

(Duration) 6 yrs. mos. ds.

CONTRIBITORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. O. Russell M. D.

, 191... (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2126 Fleet St.

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Nov 21, 191...

UNDERTAKER Wm Frankowski

ADDRESS 1618 Eastern ave

D10178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10178

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 203 N Mount ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dorsey

(Residence in Baltimore: No. 203 N Mount St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH. June (Month) 4 (Day), 1898 (Year)

7-AGE. 19 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer). At home

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Leon Cure

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Martha Hall

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Cure

(Address) 203 N Mount St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Septic Intoxication

(Duration) ... yrs. 1 mos. ... ds.

(Signed) James M Parran M. D. (Coroner)

Nov 18 1917 (Address) York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL. Laurel Cemetery

DATE OF BURIAL. Nov. 21. 1917.

20-UNDERTAKER Edward N. Pye

ADDRESS 903 E Monument

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10179 47 D10179

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 826 N. Mount St.; 16 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and Ward but No. 18.)

2-FULL NAME Gertrude Flannery

(Residence in Baltimore: No. 826 N. Mount St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. July (Month) 5" (Day), 1869 (Year)

7-AGE. 48 yrs. 4 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Isaac Rinach

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Theresa Heim

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Rinach

(Address) 826 N. Mount St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13- 1917, to Nov 18 1917, that I saw h[illegible] alive on Nov 18- 1917, and that death occurred, on the date stated above, at 1-45 m.

The CAUSE OF DEATH* was as follows: Carcinoma of thyroid gland, metastasis to liver. Pleuro-pneumonia, bilateral of both lungs, past 3 days.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of thyroid gland, metastasis

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

Nov 18, 1917. (Address) 9063 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Balto. Hebrew

DATE OF BURIAL. Nov 20..., 1917

20-UNDERTAKER [illegible]

ADDRESS [illegible]

D10180 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10180

CERTIFICATE OF DEATH.

REGISTERED No. C 182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Market Place ST. 13 WARD)

2-FULL NAME Jacob Fried

(Residence in Baltimore: No. Brookfield & Whitelock Ave. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, ~~White~~ White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH April 24" 1854
(Month) (Day) (Year)

7-AGE. 63 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 045
(a) Trade, profession, or particular kind of work Clothing Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Fried

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Sophia Getz

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertie Fried

(Address) Brookfield Ave & Whitelock St

15-

Filed ....., 191.....
Registrar.

NOV 20 1917 NOV 20 1917
ROBERT B. KRAMER'S
Burial Permit Dept.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia by Grippe
Heart weakness
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. S. Riley M. D.
(Coroner)
Nov. 18, 1917 (Address) 1637 Portsdown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem.

DATE OF BURIAL, Nov. 20 1917

20-UNDERTAKER D. Londheim

ADDRESS 118 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10181

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph Lee

(Residence in Baltimore: No. 6 Days St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR ~~RACE~~, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, Oct 12, 1899
(Month) (Day) (Year)

7-AGE, 18 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, J. Emry Lee

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER, May Hunter

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lee

(Address) Winston Salem N. C.

15-

Filed....., 191....

NOV 20 1917 ROBERT E. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13- 1917, to Nov 17- 1917, that I saw him alive on Nov 12- 1917, and that death occurred, on the date stated above, at 5 55 m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(Duration) yrs. mos. 1 ds.

(Signed) W. E. Sandy M. D.

....., 191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 6 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Winston Salem N. C.

19-PLACE OF BURIAL OR REMOVAL, Winston Salem N C. DATE OF BURIAL, Nov 20, 1917

20-UNDERTAKER Allen & Fuller ADDRESS 322 N Broad

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10182 — 29 — D10182

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 W. Lafayette Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Ann Gerhardt

(Residence in Baltimore: No. 1339 W. Lafayette Ave St.; 62 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1855 (Year)

7-AGE, 62 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry J. Tuck

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Alvesta Bebbin

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alvesta Gerhardt (Daughter)

(Address) 1339 W. Lafayette Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1915, to Nov 19 1917, that I saw her alive on Nov 19 1917, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. mos. 1 ds.

(Signed) E. Chris Murray M. D.

Nov 19, 1917. (Address) 321 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Nov 22, 1917

20-UNDERTAKER Wm C Rohde & Son — ADDRESS 730 E Balto

ROBERT A. KRAUTER
NOV 20 1917
DEPUTY REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 ✓ 310183

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1075 W. Lexington St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin H. Williams

(Residence in Baltimore: No. 1075 W. Lexington St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Store Porter
(h) General nature of Industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henderson Williams

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jane Blair

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Howard M.D.

(Address) 117 N. Carrollton Ave

15-

ROBERT E. KRAUTH

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1917, to Nov 17 1917, that I saw him alive on Nov 17 1917, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

.....

.....

..... (Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Howard M. D.

11/18, 191.7 (Address) 117 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 19 1917

20-UNDERTAKER Brown & Treland

ADDRESS 1140 W. Lexington St

C.S.P.

Spec.—8-24-14—M. & T.—2000 Bks.

D10181

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D10181

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 Argyle Ave ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Rachel Cook

(Residence in Baltimore: No. 1540 Argyle Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
45? yrs. ..... mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Cooking

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Cook

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Smith

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Cook

(Address) 1540 Argyle ave

15-

Filed ....., 191.....

ROBERT B. KRAUTER
NOV 20 1917
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Nov 16 1917, that I saw her alive on Nov 16 1917, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John C. Stewart M. D.

Nov 17, 1917. (Address) 1003 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 23 1917
20-UNDERTAKER	ADDRESS
John W Henderson	31 N Carolina

8

D10185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10185

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2331 Edmonson ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William bonnwettern

(Residence in Baltimore: No. 2331 Edmonson ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Jan (Month) 1 (Day), 1833 (Year)

7-AGE. 84 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Oyster Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer). Retired

OH 5
6155

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. William Bonderwettern

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Bonderwettern

(Address) 2331 Edmonson ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Nov. 20 1917. (Address) 1W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
London Park	Nov 21, 1917

20-UNDERTAKER	ADDRESS
William Cook	801 E North ave

D16186 HEALTH DEPARTMENT--CITY OF BALTIMORE D16186

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1234 Elling ST. 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Johns C Johnson

(Residence in Baltimore: No. above address 25 yrs St. 40 yrs. mos. ds.) in Baltimore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb. 17, 1917 (Month) (Day) (Year)

7 AGE: 60 yrs. 9 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Caterer
(b) General nature of industry, business, or establishment in which employed (or employer): Public

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: William B. Lewis

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Angeline Chase

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillie V. Johnson
(Address) 1234 Elling Street

15 Filed ..... 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 18, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1917 to Nov 18 1917.
that I saw h[illegible] alive on Nov 17 1917.
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) acute dilatation

(Duration) Suddenly yrs. mos. ds.

(Signed) I C Blackshaw M. D.
Nov 20, 1917 (Address) 1008 Cathedral st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov. 21, 1917

20 UNDERTAKER: John A. Bishop — ADDRESS: 1107 Druid Hill Ave.

Is very important. See instructions on back of certificate.

NOV 20 1917 Burial Permit Clerk

D10187

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 ✓ D10187

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 922 Jenkins St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Downs

(Residence in Baltimore: No. 922 Jenkins St.; 5 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May (Month) 10 (Day) 1885 (Year)

7-AGE: 32 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Market porter
(b) General nature of industry, business, or establishment in which employed (or employer):
766 186

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Albert Downs

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Annie Price

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Downs

(Address) 922 Jenkins St

15-

Filed ....., 191 .....

Burial Permit Dept

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 16 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 1917, to, Nov 16 1917, that I saw him alive on Nov 15 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs 8 mos. — ds.

Contributory (SECONDARY) —

(Duration) yrs mos. ds.

(Signed), H. C. Belletsius M. D.

Nov 15, 1917. [Address] 817 Hamilton Ter

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem. DATE OF BURIAL: Nov 20, 1917

20-UNDERTAKER: Samuel J. Wensley ADDRESS: 578 W. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D10188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D10188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Mason ST.; 11 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alex Wahnson

(Residence in Baltimore: No. 1123 Mason St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Nov 17, 187[illegible]
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Gaither

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Johnson

(Address) 527 Pratt St

15-

Filed ....., 191.....

NOV 20 1917 ROBERT S. KRAUTER Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov 17 1917, that I saw h[illegible] alive on Nov 17 1917, and that death occurred, on the date stated above, at 11.6 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Abscess (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D.

Nov 20, 1917. (Address) 512 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 21, 191[illegible]

20-UNDERTAKER David L Hamby — ADDRESS 578 W Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

D10180 HEALTH DEPARTMENT—CITY OF BALTIMORE D10180

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Gilmor ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Kavanagh

(Residence in Baltimore: No. 530 N. Gilmor St.; 4 yrs., 10 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1912 (Year)

7-AGE, 4 yrs. 10 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Kavanagh

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Kavanagh

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kavanagh

(Address) 530 N. Gilmor st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 19 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17 1917, to Nov 19 1917, that I saw her alive on Nov 19 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Asphyxiation, Suicide by Intoxication

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Laryngeal Dyspnoea,

(Duration) .... yrs. .... mos. .... ds.

(Signed) C. H. Meyer & Co. M. D.

Nov 19, 1917. (Address) 24 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery. DATE OF BURIAL, Nov 20, 1917.

20-UNDERTAKER Christian Miller ADDRESS 2334 Jefferson st

Spec.—8-24-14—M. & T.—2000 Bks.

D10190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10190

CERTIFICATE OF DEATH.

REGISTERED No. C 19179

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. 102 Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fannie Kisner -

(Residence in Baltimore: No. 203 S. Calhoun St.; 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 6, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER, Philip L. Bichell -

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER Margaret A. Murray

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. L. Hammer

(Address) 203 S Calhoun St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 20 1917, to Nov 18 1917, that I saw h er alive on Nov 18 1917, and that death occurred, on the date stated above, at 7 35 P.M.

The CAUSE OF DEATH* was as follows:

"Mitral regurgitation or Chronic Valvular heart disease"

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
General Oedema (Duration) yrs. 4 mos. ds.

(Signed) H. R. Kisner M. D.

Nov. 18, 1917 (Address) Franklin Sq. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 20, 1917.

20-UNDERTAKER Wm J. Fields 1200 W Lombard — ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10191 D10191

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2615 Dulany ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bach

(Residence in Baltimore: No. 2615 Dulany St.; yrs., 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 11 (Day) 1917 (Year)

7-AGE, yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Bach

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Annie Wright

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Bach

(Address) 2615 Dulany St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 191 7, to Nov 19 191 7, that I saw him alive on Nov 18 191 7, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Ac. Bronchi-
Pneumonia
Primary (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
..... (Duration) yrs. mos. ds.

(Signed) W. Thuel M. D.

11/19, 191 7. (Address) Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, Nov 20, 1917

20-UNDERTAKER John J. Fields — ADDRESS 1700 W Lombard

ROBERT B. BEAUFORT
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10192 D10192 61

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Belvedere St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Herbert Mason

(Residence in Baltimore: No. 808 N. Belvedere St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sing

6-DATE OF BIRTH, June (Month) 15 (Day), 1916 (Year)

7-AGE, 1 yrs. 7 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work No
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. James E. Mason

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co. Md

12-MAIDEN NAME OF MOTHER Gemma Reid Joy

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Herbert Mason

(Address) 808 N. Belvedere Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 18 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov. 18 1917, to Nov 18 1917, that I saw h[illegible] alive on Nov 18 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Rowe M. D.

Nov. 19, 1917. (Address) 1008 Eastlandale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore cemetery

DATE OF BURIAL, Nov. 19, 1917.

20-UNDERTAKER J. J. Hartley

ADDRESS 202 E Madison St

Reg. 2716 R

Spec.—8-24-14—M. & T.—2500 Blks.

D10193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D10193

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 N Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Schmich

(Residence in Baltimore: No. 1111 N Bond St.: ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 27 (Day), 1893 (Year)

7-AGE, 23 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirt Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Schmich

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Catherine Foos

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine Schmich

(Address) 1111 N Bond St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Abt Jan 1 1917, to Nov 17 1917, that I saw him alive on Nov 17 1917, and that death occurred, on the date stated above, at 11.15 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) about 1 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Wm. L. Ingram M. D.

Nov 19, 1917. (Address) 2437 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Nov 20, 1917

20-UNDERTAKER Mc Ginnis-Carroll ADDRESS 602 N. Potomac St

Spec.—8-24-14—M. & T.—2000 Bks.

D10191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D10197

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 S Potomac ST.; [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Takiena Kowalewicz

(Residence in Baltimore: No. 810 S. Potomac St St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Male~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. (Month) 11 (Day), 1917 (Year)

7-AGE, ... yrs. ..... mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank Kowalewicz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Tikla Pavacik

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Kowalewicz

(Address) 810 S. Potomac St

15-

Filed ....., 191.....

Registrar.

C. S. P.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10th 1917, to Nov. 19th 1917, that I saw h alive on " " 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pertussis Bronchalorum

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob F. Wimer M. D.

11-20, 1917. (Address) 30 S. B'way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, 1st German Evg. Lutheran — DATE OF BURIAL, Nov. 20, 1917.

20-UNDERTAKER Stephen J. Fralkowski — ADDRESS 1007 S. Eaton St

Spec.—8-24-14—M. & T.—2000 Blks.

D10195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10195

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 E. Monument ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie W. Soellner.

(Residence in Baltimore: No. 2600 E. Monument St.; 20 yrs., 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 13th, 1897 (Month) (Day) (Year)

7-AGE, 20 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Albertus Soellner

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Madaline Kisperl

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albertus Soellner

(Address) 2600 E. Monument

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5th 1916, to Nov. 17 1917, that I saw her alive on Nov. 17 1917, and that death occurred, on the date stated above, at 4 P.t m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Laryngeal Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 1 yrs. 11 mos. ds.

(Signed) Cora Schmidt M. D.

Nov. 18, 1917 (Address) 701 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 21st, 1917

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Mo...

Spec.—8-24-14—M. & T.—2000 Bks.

Samuel E. Triggs.

D10196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10196

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 S Bond ST.; 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel E Triggs

(Residence in Baltimore: No. 850 S. Bond St.; .....yrs., 2 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 18 (Day) 1917 (Year)

7-AGE, ...yrs. 2 mos. ~~2~~ 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel H Triggs

11-BIRTHPLACE OF FATHER (State or Country), Martinsburgh W. Va

12-MAIDEN NAME OF MOTHER Agnes L. Jachalski

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel H. Triggs

(Address) 850 S. Bond St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1917, to Nov 14 1917, that I saw h.. alive on Nov 14 1917, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary.

..... (Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY..... Heart failure
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Wm. A. Mullick M. D.

11-19..., 1917 (Address) 1621 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, 11.20....., 1917.

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S Ann St

E. S. P.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10197

CERTIFICATE OF DEATH.

B10197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St.; 18 Ward) REGISTERED NO. C 109

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lennert

(Residence in Baltimore: No. 823 W Mulberry St.; 59 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, June (Month) 30 (Day), 1854 (Year)

7-AGE, 76 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lennert 502 Ch

(Address) Have no information in history

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1917, to Nov 18 1917, that I saw him alive on Nov 9 1917, and that death occurred, on the date stated above, at 11:35 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Alcoholism (Duration) ....yrs. ....mos. 2 ds.

(Signed) J. A. Bardon M. D.

Nov 19, 191 7. (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State ....yrs. ....mos. 2 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 823 W. Mulberry

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov 21 1917

20-UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

S.

Spec.—8-24-14—M. & T.—2000 Bks.

D1019S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1019S

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S Linwood St.; 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Larkin Isaac Brownley

(Residence in Baltimore: No. 624 S Linwood St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 27 (Day), 1830 (Year)

7-AGE, 87 yrs. 3 mos. 20 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Ship Yards

9-BIRTHPLACE, (State or Country), V. A.

PARENTS.

10-NAME OF FATHER, John Brownley

11-BIRTHPLACE OF FATHER (State or Country), V. A.

12-MAIDEN NAME OF MOTHER Johanna Samuels

13-BIRTHPLACE OF MOTHER (State or Country), V A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor Brownley

(Address) 624 S. Linwood

15-

Filed....., 191..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 17 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 1916, to Nov 17 1917, that I saw him alive on Nov 16 1917, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis (Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Atkey M. D.

Nov 19, 1917 (Address) 624 S Linwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Nov 20 1917

20-UNDERTAKER Kendall Uffelman — ADDRESS 378 Pac

S

Spec.—8-24-14—M. & T.—2000 Bks.

D10199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Warren Ave ST.; 24 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E Martin

(Residence in Baltimore: No. 303 Warren ave St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH Oct. 11th, (Month) (Day) 1837 (Year)

7-AGE 80 yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Companion
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co Md.

PARENTS.

10-NAME OF FATHER, Walter Martin

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Vroy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin T. Parlett

(Address) 303 Warren Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH November 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1917, to Nov 18th 1917, that I saw her alive on Nov 18th 1917, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) ~~yrs.~~ 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T J O'Donnell M. D.

Nov 19th, 1917 (Address) 1875 West St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park, DATE OF BURIAL, Nov 20, 1917.

20-UNDERTAKER Anthony Bamy Co ADDRESS 315-317 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D10200 D10200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+79

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hop. Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Wolfe.

(Residence in Baltimore: No. 7 days St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 22, 1902
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
15 yrs. 1 mos. 7 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clifford Wolfe

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Louise Stone

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 - 1917, to Nov 19 1917, that I saw him alive on Nov 19 - 1917, and that death occurred, on the date stated above, at 5 00 p.m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 9 mos. 1 ds.

(Signed) H. E. Handley M. D.

Nov. 20, 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Monrovia Md.

19-PLACE OF BURIAL OR REMOVAL, Brownsville Md. DATE OF BURIAL, Nov 20, 191.7.

20-UNDERTAKER E. B. Hall ADDRESS 115 Ellen

Spec.—5-19-13—M. & T.—500 Bks.

D10201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10201

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 N. Bethel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank L. Holland

(Residence in Baltimore: No. 1418 N. Bethel St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.): Married

6-DATE OF BIRTH, Nov. 29th (Month) (Day), 1888 (Year)

7-AGE, 28 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car inspector
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Frank Holland.

11-BIRTHPLACE OF FATHER (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Belle Smith

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Pearl Holland.

(Address) 1418 N. Bethel st

15-

NOV 20 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

5

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1917, to Nov. 18, 1917, that I saw him alive on Nov. 18, 1917, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Fenby, M. D.

Nov. 19, 1917. (Address) 1223 N. Caroline st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov. 21, 191...

20-UNDERTAKER George F. Ruth

ADDRESS 1735 Hayford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10202 D10202 151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH 805 Harford Ave.

CITY OF BALTIMORE: (No. ..... ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Green

(Residence in Baltimore: No. 805 Harford Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	

6-DATE OF BIRTH, Nov 17, 1917
(Month) (Day) (Year)

7-AGE, 1 year
.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Green

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Connie Wills

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Murray Jones

(Address).....

15-

Filed....., 191.....
Registrar.

NOV 20 1917 ROBERT E. PREACHER Burial Permit Clerk

L 5305 S

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1917, to Nov 17 1917, that I saw h[illegible] alive on Nov 17 1917 and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows:

Premature Rupture of Membranes

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... Premature birth
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John E. Murray Jr. M. D.

....., 191... (Address) Johns Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL.	Nov 19, 1917
20-UNDERTAKER	ADDRESS

Commissioner Health.
Per Wm. E. WOODALL

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10203 **CERTIFICATE OF DEATH.** 28 D10203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Johnson

(Residence in Baltimore: No. St. Elizabeth's Home St.; 14 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	negress	

6-DATE OF BIRTH, ... (Month) ..... (Day) 1903 (Year)

7-AGE,	If LESS than 1 day,
14 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John F. Stevens

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Teresa Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 10 1917, to Nov. 16 1917, that I saw h.r alive on Nov 16 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

.....

(Pneumonia Contributory Influenza)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J. Lloyd M. D.

Nov 18, 1917. (Address) 1211 E. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	....., 191...
20-UNDERTAKER (Commissioner Health.)	ADDRESS

NOV 20 1917 ROBERT B. BRADEN JOHNS HOPKINS HOSPITAL BURIAL PERMIT

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10201 D10204

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD) REGISTERED No. C .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Thomas

(Residence in Baltimore: No. St. Elizabeths Home St.; 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	negress	

6-DATE OF BIRTH, ... (Month) ..... (Day) 1906. (Year)

7-AGE, 11 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 0

9-BIRTHPLACE, (State or Country), Cond't unknown

PARENTS.

10-NAME OF FATHER, Cannot be learned

11-BIRTHPLACE OF FATHER (State or Country), the State

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Nov. 16 1917, that I saw h.. alive on Nov 16 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J Ayd M. D.

Nov. 18, 1917. (Address) 1247 E. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	NOV 19 1917 ....., 191...
20-UNDERTAKER	ADDRESS
Commissioner Health.	

NOV 20 1917 ROBERT E. LEE

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10205 D10205

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH The Johns Hopkins Hospital REGISTERED NO. C.

CITY OF BALTIMORE: (No. ..... St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Dunnoch.

(Residence in Baltimore: No. ..... St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Black	Single

6-DATE OF BIRTH, Nov 15, 1917.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, James Dunnoch

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Willie Dunnoch

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Nov 15 1917, that I saw him alive on Nov 15 1917, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis
Premature birth (Immaturity)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) for (Dr. Thomas McCrae) M. D.

Nov 16, 191.7 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	Nov 19, 1917
20-UNDERTAKER	ADDRESS
Commissioner Health	
Per. Wm. E. Woodall	

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10206 D10206

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1626 N. Vincent ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Smith

(Residence in Baltimore: No. 1626 N. Vincent St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, November 18, 1917.
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 10 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Walter Smith

11-BIRTHPLACE OF FATHER (State or Country), Pittsburgh, Pa.

12-MAIDEN NAME OF MOTHER Caroline S. Braxton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 18 1917, to November 19 1917, that I saw him alive on November 19 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Premature

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. H. Douglas M. D.

Nov. 19, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 20 1917

Commissioner Health.

Per. Wm. E. ROSSELL

15312

Spec.—8-24-14—M. & T.—2000 Blks.

D10207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10207

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1455 Covington ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bell

(Residence in Baltimore: No. 1455 Covington St.; ....yrs.,.... mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dont Know (Month) (Day), 1864 (Year)

7-AGE,	If LESS than 1 day,
53 yrs. ... mos. ... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Ireland ~~Penn~~

PARENTS.

10-NAME OF FATHER, James Bell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catharine Bell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Harry Benson

(Address) 1433 Covington St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Nov. 18 1917, that I saw h[illegible] alive on Nov 16 1917, and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ....yrs. 11 mos. ....ds.

CONTRIBUTORY (Secondary) ~~Cancer~~

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A Sheridan M. D.

Nov 19, 1917 (Address) 1228 E Preals

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	Nov 21, 1917

20-UNDERTAKER	ADDRESS
Margaret G. Flynn	1432 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10208 ✓ 145 D10208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 W. Pandall ST.; 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Neidrick.

(Residence in Baltimore: No. 102 W. Pandall St ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	White	Married

6-DATE OF BIRTH, ... Mar. 5 ....., 1851
(Month) (Day) (Year)

7-AGE, 66 yrs. 8 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) 1037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nicholas Neinick.

11-BIRTHPLACE OF FATHER (State or Country), Europe.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Europe.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jno. Neidrick.

(Address) ..... 1507 Clarkson St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 20 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 1917, to Nov 20 1917, that I saw h er alive on Nov 20 1917, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage. Rupture of Int. Saphenous Vein

..... (Duration) ..... yrs. ..... mos. 1 ds. Instan

CONTRIBUTORY (Secondary) Leg ulcer

..... (Duration) 35 yrs. ..... mos. ..... ds.

(Signed) ..... Philip B. Taylor M. D.

Nov. 20, 1917. (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem.	Nov. 23 ....., 1917
20-UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X1

D10209

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. University Hospital Lombard & Greene ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Violet Watkins

(Residence in Baltimore: No. Laurel Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, [illegible] (Month), ... (Day), 1907 (Year)

7-AGE, 10 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

9-BIRTHPLACE, (State or Country), Laurel Md.

PARENTS.

10-NAME OF FATHER, Charles Watkins

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Records

(Address) .....

15-

Filed ....., 191.....

Registrar.

NOV 20 1917 ROBERT R. CRAUTEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 20 1917, that I saw h[illegible] alive on Nov 20 1917, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Pleurisy C

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) D. P. Eller M. D.

11/20, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State 10 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Laurel Md.

Former or usual residence Laurel "

19-PLACE OF BURIAL OR REMOVAL, Laurel Md — DATE OF BURIAL, Nov 22, 1917

20-UNDERTAKER Geo. F. Gerber — ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10210

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp (St.) 19 (Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm George Mercier

(Residence in Baltimore: No.) 30 N. Mount St (St.); .....yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ....., (Day) 1 (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 063

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Isiah Mercier

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER [redacted] known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. A. Hillenger

(Address) Ellicott City

15-

NOV 20 1917 ROBERT N. KRAUTZ

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1917, to Nov 20 1917, that I saw h[illegible] alive on Nov 20 1917, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

.....

.....

..... (Duration) .....yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Egbert L. Mathias M. D.

Nov 20, 1917. (Address) 530 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 9 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 30 N. Mount St.

19-PLACE OF BURIAL OR REMOVAL, St Johns Cemetery — DATE OF BURIAL, Nov. 22, 1917.

20-UNDERTAKER L. Hillenger & Son — ADDRESS Ellicott City

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10211 D10211

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Mc Culloh ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Lewis.

(Residence in Baltimore: No. 1803 Mc Culloh St.; 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1861 (Year)

7-AGE, 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: maid
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Truman Grey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lucie Truman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lewis

(Address) 1803 Mc Culloh St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 26 191 , to Nov. 19 1917, that I saw her alive on Nov. 17 191 , and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Aortic Dilatation

(Duration) yrs. 3 mos. wks.

CONTRIBUTORY (Secondary) Pulmonary Oedema (Duration) yrs. mos. ds.

(Signed) W. L. Carr M. D.

....., 191... (Address) 515 Fairfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 22, 1917
20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 N Carey

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10212

CERTIFICATE OF DEATH.

104

D10212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Lemadm ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Snowden

(Residence in Baltimore: No. 1226 Pennsylvania Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Blk.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 4 da (Day), 1917 (Year)

7-AGE, ...yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 001

9-BIRTHPLACE, (State or Country), Baltimore - Md -

PARENTS.

10-NAME OF FATHER, Clifton Jones -

11-BIRTHPLACE OF FATHER (State or Country), Baltimore - Md.

12-MAIDEN NAME OF MOTHER Emma Snowden

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Watts

(Address) 1226 Penna - Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 17 1917, to November 19 1917, that I saw h er alive on November 19th 1917, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Acute gastro - enteritis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Bertha E. Tapman M. D.

November 1917. (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 21, 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D10213

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 D10213

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Hamplin

(Residence in Baltimore: No. 519 N Bond Street St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 1, (Month) (Day) (Year)

7-AGE, 53 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Chester S.C.

PARENTS.

10-NAME OF FATHER, Ben Hamplin

11-BIRTHPLACE OF FATHER (State or Country), Chester S.C.

12-MAIDEN NAME OF MOTHER McKenzie

13-BIRTHPLACE OF MOTHER (State or Country), McKenzie

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Rich

(Address) J H Hospital

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1917, to Nov. 19 1917, that I saw him alive on Nov. 19 1917, and that death occurred, on the date stated above, at 10⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Primary cause Pneumonia.

Secondary Pneumonia Lobar left lower lobe

14 years (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

3 weeks (Duration) ... yrs. ... mos. ... ds.

(Signed) A R Bloomfield M. D.

Nov. 19, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 4 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 519 N. Bond ST.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov. 21, 1917.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 East ...

NOV 21 1917 ROBERT E. KRAUTZ BURIAL PERMIT CLERK

D10211

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

D10211

1 PLACE OF DEATH

CITY OF BALTIMORE (No 1882 Stockton ST. 15 WARD)

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mathews

(Residence in Baltimore: No. 1382 Stockton St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M

4-COLOR OR RACE Col

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Nov 18, 1 (Month) (Day) (Year)

7-AGE 11 hours ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 11 hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or country) Md

PARENTS

10-NAME OF FATHER Harry Mathews

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Lady Myers.

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dlorie Meyers

(Address) 1382 Stockton St

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov 18, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1917, to 18 1917, that I saw h[illegible] alive on Nov 18, 1917, and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature birth

11 hours

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. A. Melching M. D.

Nov 20, 1917 (Address) 1303 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodlawn — DATE OF BURIAL Nov 21, 191[illegible]

20-UNDERTAKER David Eaton — ADDRESS 816 [illegible]

is very important. See instructions on back of certificate.

D10215 HEALTH DEPARTMENT—CITY OF BALTIMORE D10215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1207 Hugh Alley ST.; 5 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis C Nabe

(Residence in Baltimore: No. 1207 Hugh Alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, Nov 10th, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Confectionery Ofc
(b) General nature of industry, business, or establishment in which employed (or employer): Confectionery

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Louis Nabe

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaretha

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nabe

(Address) 1207 Hugh Alley

15-

Filed....., 191.....
Registrar.

ROBERT B. KRAUTER
NOV 21 1917
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Mitchell Sunday M. D.
(Coroner.)

Nov 17, 191... (Address) 1 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Nov. 21, 1917
20-UNDERTAKER	ADDRESS
L. Sander Sons	120 East St

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10216 D10216

CERTIFICATE OF DEATH.

108

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602, Hollins ST.: 19 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Catherine Brown

(Residence in Baltimore: No. 1602 Hollins, St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sing'l

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. John M. Brown

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Sophia Boyd

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ray Brown

(Address)..... 1602 Hollins St

15-

Filed....., 191.....

ROBERT E. LEAUTY, Registrar. Burial Permit Clerk. NOV 21 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1917, to Nov 18 1917, that I saw her alive on Nov 18 1917, and that death occurred, on the date stated above, at 11 m

The CAUSE OF DEATH* was as follows:

.....

Appendicitis

.....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Gen. Peritonitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lamplugh M. D.

Nov 20 1917. (Address) 826 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mud Ridge Com — DATE OF BURIAL, Nov 21 1917

20-UNDERTAKER W. E. Schnorbus — ADDRESS Mount Vale

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10217 D10217

CERTIFICATE OF DEATH.

+1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; H WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Watts

(Residence in Baltimore: No. Upper Falls Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	

6-DATE OF BIRTH, February 12, 1863
(Month) (Day) (Year)

7-AGE, 53 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo Watts

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Nellie Foster

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hosp.

(Address)

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1917, to Nov. 20 1917, that I saw him alive on Nov. 20 1917, and that death occurred, on the date stated above, at 1.25 P m. The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

, 191... (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Upper Falls Md

Former or usual residence Upper Falls Md

19-PLACE OF BURIAL OR REMOVAL, Baltimore Md — DATE OF BURIAL, Nov 22, 1917

20-UNDERTAKER W J Pechmann — ADDRESS North Ave

NOV 21 1917
ROBERT B. KRAUTH
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10218

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Schmidt

(Residence in Baltimore: No. 529 N Castle St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Sept 1, 1857.
(Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Christian Braun

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Godfried Schmidt

(Address) 529 N Castle St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1916, to Nov 18 1917, that I saw h-er alive on Nov 18 1917, and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Zahner M. D.

11/19, 1917. (Address) 218 E. Baltic St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Schwartz Cemetery

DATE OF BURIAL, Nov 21, 1917.

20-UNDERTAKER John Herring & Co

ADDRESS 2008 Eastern Ave

D10219

HEALTH DEPARTMENT—CITY OF BALTIMORE

1PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 19 WARD)

CERTIFICATE OF DEATH.

174 D10219

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Cure

(Residence in Baltimore: No. 803 N. Vincent St St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE. 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Cure

(Address) 503 N. Vincent St.

15-

Filed....., 191.....

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., (Month) Nov 17, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull Cause by falling down Elevator Shaft (accident)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Driscoll (Coroner) M. D.

Nov 20, 1917. (Address) 211 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Nov. 20, 1917

20-UNDERTAKER Boarman & Finlander — ADDRESS 114 N. Howard St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10220 D10220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Argyle Ave ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Savage

(Residence in Baltimore: No. 1136 Argyle Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH, Oct. (Month) 25 (Day), 1915 (Year)

7-AGE,	If LESS than 1 day,
2 yrs. 1 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER, George E. Savage

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Edrick Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy Savage

(Address) 1136 Argyle Ave

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 19th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Nov. 19th 1917, that I saw h[illegible] alive on Nov. 18 1917, and that death occurred, on the date stated above, at 12 56 (p) m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

..... (Duration)....yrs....mos....10....ds.

CONTRIBUTORY (Secondary) Measles

..... (Duration)....2....yrs.....mos.....ds.

(Signed) Geo. H. Holland M. D.

Nov. 20, 1917 (Address) 1131 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Cemetery	Nov. 21, 1917.
20-UNDERTAKER	ADDRESS
Geo H Holland	1631 Druid Hill Ave

NOV 21 1917 [illegible] Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1021 D1021

CERTIFICATE OF DEATH.

9 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Harris Alley ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Pisco

(Residence in Baltimore: No. 906 Harris Alley Stay 4½ yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Nov. 1, 1[illegible]
(Month) (Day) (Year)

7-AGE, 6 yrs. mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Pisco

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mary Kral

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Pisco

(Address) 906 S. Harris Alley

15-

Filed ..., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Nov 20 1917, ~~to 191~~, that I saw ~~him~~ alive on Nov 20 1917, and that death occurred, on the date stated above, at 6p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ca 1 day yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. H. Sammarth M. D.

Nov 20, 1917. (Address) 2403 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Nov 21, 1917.

20-UNDERTAKER Stephen J. Fialkowski

ADDRESS [illegible]

NOV 21 1917 Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D10222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10222

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.; [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah E Collison

(Residence in Baltimore: No. Md. General Hosp. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 30 (Day), 1860 (Year)

7-AGE, 57 yrs. 5 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, A. B. Collison

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Sarah Rise

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Collison

(Address) Md Gen Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 20 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov. 4— 1917, to Nov. 20 1917, that I saw h[illegible] alive on Nov. 20 1917, and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) [signature] M. D.

Nov 24, 1917 (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 16 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Easton - Md -

19-PLACE OF BURIAL OR REMOVAL, Easton Md

DATE OF BURIAL, Nov. 23, 1917

20-UNDERTAKER Wm Cook

ADDRESS 503 E. Mont

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10223 ✓ D10223

CERTIFICATE OF DEATH.

78

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 N. Carey ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Miller

(Residence in Baltimore: No. 337 N. Carey St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6-DATE OF BIRTH, July (Month) 31 (Day) 1857 (Year)

7-AGE, 50 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Mayenscheim

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna M. Singer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Miller

(Address) 337 N. Carey St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1910, to Nov. 19 1917, that I saw h alive on Nov 6 1917, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia → Carcinoma → Pylorus

Cancer → Stomach → Intestines

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(Duration) 4.0 yrs. mos. ds.

(Signed) Charles G. Miller M. D.

Nov 20, 1917 (Address) Arlington Hotel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk DATE OF BURIAL, Nov. 22, 1917

20-UNDERTAKER Wm. Cook ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Bks.

D10221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10221

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 E Fort ave ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Jackson Seward

(Residence in Baltimore: No. 1612 E Fort Ave St. Lib yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 9, 1853 (Month) (Day) (Year)

7-AGE, 64 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Grain 086
(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William Seward

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Catherine Shickels

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie F. Seward

(Address) 1612 E Fort Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Nov 20 1917, that I saw him alive on Nov 20 1917, and that death occurred, on the date stated above, at 9.50 m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) 1 yrs. mos. 3 ds.

(Signed) John D Kolb M. D.

Nov 20, 1917. (Address) 120 S High St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemt — DATE OF BURIAL, Nov 23, 1917

20-UNDERTAKER Wm Cook — ADDRESS 501 E 20th

Spec.—8-24-14—M. & T.—2000 Bks.

D10225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10225

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 E Fort ave St.; 2d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Noon

(Residence in Baltimore: No. 1304 E Fort ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Widowed

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 71 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Jim Coyne

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Noon

(Address) 1304 E Fort a

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1917, to Nov 19 1917, that I saw h[illegible] alive on Nov 19 1917, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) Jas A O'Donnell M. D.

Nov 19, 191.. (Address) 607 Mad St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Nov 22, 1917

20-UNDERTAKER E Manning — ADDRESS 1460 Battery

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10226

92 [illegible]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp ST.: 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bangert

(Residence in Baltimore: No. 317 S. Madeira St.: 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month), (Day), 1883 (Year)

7-AGE, 34 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, John Bangert

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Bangert

(Address) 317 S. Madeira St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1917, to Nov 18 1917, that I saw him alive on Nov 18 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 7 ds.

(Signed) H Herbst M. D.

Nov. 18, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 317 S Madeira St

19-PLACE OF BURIAL OR REMOVAL, Int. Lauralson

DATE OF BURIAL, Nov. 21 191.7

20-UNDERTAKER John A. Inman

ADDRESS 3000 E Balto St

E. S. P.

Spec.—8-24-14—M. & T.—2000 Bks.

Mrs Annie Eliza McDermott.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1200 ✓

REGISTERED NO. C 11,027

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2139 N. North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Annie Eliza McDermott

(Residence in Baltimore: No. 2139 N. North Ave St.; ..... yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept. ✓, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), New York N. Y.

PARENTS.

10-NAME OF FATHER, Matthew Sreville

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Ellen Cullen.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George C. Shannon
(Address) 700 Fulton Ave

15-
NOV 21 1917
Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17 1917, to Nov 20 1917, that I saw her alive on Nov 19 1917, and that death occurred, on the date stated above, at 9.25 p. m.

The CAUSE OF DEATH* was as follows:

Coma and Paralysis

(Duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Chronic Nephritis

(Duration) 4 yrs. ✓ mos. ✓ ds.

(Signed) George C. Shannon M. D.

Nov 20, 1917 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Nov. 22 1917.

20-UNDERTAKER M. Fahey & Sons — ADDRESS 1062 Lafayette Ave

C. S. P.

Spec.—8-24-14—M. & T.—2000 Bks.

D1028 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D1028

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 N. Montford Ave St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Hadrill

(Residence in Baltimore: No. 1711 N. Montford Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 11 (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
67 yrs. 6 mos. 8 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jonathan Orr

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Foster

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Clara E. Hanson.....

(Address)...1711 N. Montford Ave.....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Nov 19 1917, that I saw h[er] alive on Nov 18 1917, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

.....Pneumonia, Lobar.....

..... (Duration) ?? yrs. ?? mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Wm S. Keator M. D.

Nov 19, 1917. (Address) 2128 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Angel Hill Cemetery Havre de Grace | DATE OF BURIAL, NOV 22 1917

20-UNDERTAKER ARMSTRONG-DENNY CO. | ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Blks.

D10220 D10220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79v

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Rutland Ave ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Keyser

(Residence in Baltimore: No. 1039 Rutland Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 4th (Day) 1895 (Year)

7-AGE, 22 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, Robert H. Reddick

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Anna Stewart

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Beatrice Johnson

(Address) 1039 Rutland Ave

15-

Filed....., 191.....

ROBERT B. KRAUSS NOV 21 1917
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 20th (Day) 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov 13th 1917, to Nov 20th 1917, that I saw h.. alive on Nov 19th 1917, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 1 yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Chorea

(Duration) ....yrs. ....mos. 1 ds.

(Signed) D. A. Stull M. D.

Nov 20th 1917, 191... (Address) 1501 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, BALTIMORE CEMETERY. DATE OF BURIAL, NOV. 23 1917

20-UNDERTAKER ARMSTRONG-DENNY CO. ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D10230 HEALTH DEPARTMENT—CITY OF BALTIMORE D10230

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Caroline ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genevieve Agnes Foley

(Residence in Baltimore: No. 1501 Caroline St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... Mar. (Month) 29 (Day), 1897 (Year)

7-AGE, ... 20 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John T. Foley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Annie Luby

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank T. Foley

(Address) 1501 N. Caroline St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about May 1917, to Nov. 20 1917, that I saw h[illegible] alive on May 19 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Valv. disease heart .....

.....

.....

..... and then (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmon. tuberculosis

..... (Duration).....yrs.....mos.....ds.

(Signed) W. J. Foley M. D.

Nov 21, 191.7 (Address) 1629 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Nov. 22, 191.7

20-UNDERTAKER H. C. Wiedefeld

ADDRESS 1st Eutaw St.

Spec.—8-24-14—M. & T.—2000 lks.

D10231 D10231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margarett King

(Residence in Baltimore: No. 218 S. Castle St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. ....., 1 ..... (Month) (Day) (Year)

7-AGE. 3 yrs. ..... mos. ..... da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. David King

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jennie Hulchuch

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15- NOV 21 1917 ROBERT E. CLAYTON

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17 1917, to Nov. 20 1917, that I saw her alive on November 20 1917, and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

..... (Duration) ..... yrs. ..... mos. 21 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 13 da.

(Signed) I. M. Kerr M. D.

Nov. 21, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 24 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 218 S. Castle St

19-PLACE OF BURIAL OR REMOVAL. Lot Redgrave Cemetery DATE OF BURIAL. Nov 23 1917

20-UNDERTAKER George J. Roth ADDRESS 1735 Hanford Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D10232 D10232 D10232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 E Oliver ST.; 8 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Seipp

(Residence in Baltimore: No. 1626 E Oliver st St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 20 (Day), 1839 (Year)

7-AGE, 78 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Schnabel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Seibert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Seipp

(Address) 1626 E Oliver St

15-

Filed ....., 191.....

Registrar.

NOV 21 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9th 1917, to Nov. 21 1917, that I saw h.r alive on Nov. 20 1917, and that death occurred, on the date stated above, at 1.30a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. G. Sandrock M. D.

Nov. 21, 1917. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov. 23, 1917
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10233

CERTIFICATE OF DEATH.

17 10233

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Adams

(Residence in Baltimore: No. 104 S. East St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) —

6-DATE OF BIRTH, Dec. 14, 1880
(Month) (Day) (Year)

7-AGE, 36 yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Andrew Adams

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Smick

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hospital

(Address) .....

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 1917, to Nov. 22 1917, that I saw him alive on Nov. 22 1917, and that death occurred, on the date stated above, at 3.15 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Could get no autopsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward E. Smith M. D.

....., 191... (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 12 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 104 S. East St

Former or usual residence 104 S East St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 24 1917

20-UNDERTAKER W J Tasker

ADDRESS North Ave

D1023[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1023[illegible]

CERTIFICATE OF DEATH.

REGISTERED No. C 16 × 184

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert C. Skinner

(Residence in Baltimore: No. 1012 W Lanvale St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan (Month) 2 (Day), 1912 (Year)

7-AGE,	If LESS than 1 day,
5 yrs. 10 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Edwin S Skinner

11-BIRTHPLACE OF FATHER (State or Country), Rhode Island

12-MAIDEN NAME OF MOTHER Carolyn Craig

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin S Skinner Sr

(Address) 1012 W Lanvale St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bichloride Mercury Poison administered by party unknown to jury 10 hours (Duration)

CONTRIBUTORY (Secondary) (Duration)

(Signed) James M Benton M. D. (Coroner.)

Nov 14 1917 (Address) 7 W Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

10 hours

Where was disease contracted, if not at place of death? Harlem Square

Former or usual residence 1012 W Lanvale

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 22 1917
20-UNDERTAKER Geo W. Little	ADDRESS 531 N. Fremont Ave

D10235 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10235

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St. 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin A. Skinner

(Residence in Baltimore: No. 1012 W Lanvale St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
male	white	Single

6-DATE OF BIRTH, Oct (Month) 4 (Day), 1914 (Year)

7-AGE	If LESS than 1 day,
3 yrs. 1 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). New Jersey

PARENTS.

10-NAME OF FATHER, Edwin G Skinner

11-BIRTHPLACE OF FATHER (State or Country) Rhode Island

12-MAIDEN NAME OF MOTHER Carolyn R Craig

13-BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin G Skinner

(Address) 1012 W Lanvale St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Pulmonary Administered

by party unknown to Jury

(Duration) yrs. 4 mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

Nov 24 191 7 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. ds. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death? Harlem Sanitarium

Former or usual residence 1012 W Lanvale St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov 21 1917

20-UNDERTAKER	ADDRESS
Geo. W. Little	531 N Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10236 6 — D10236 64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1538 N. Milton Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. Schwarzkopf

(Residence in Baltimore: No. 1538 N. Milton Ave St.: 73 yrs., 1 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, October 20, 1844 (Month) (Day) (Year)

7-AGE, 73 yrs. 1 mos. ds. — If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Bernard C. Pruntz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Schwarzkopf

(Address) 1538 N. Milton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1917, to Nov 20 1917, that I saw h[er] alive on Nov 20 1917, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.

Nov 21, 191.7 (Address) 1301 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, November 24 1917.

20-UNDERTAKER Henry Horck Son — ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D10237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10237

1-PLACE OF DEATH University Hospital. REGISTERED No. C

CITY OF BALTIMORE: (No. 27 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William White

(Residence in Baltimore: No. 109 N. Hughes St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, [redacted]

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) 074

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Jacob White

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Hattie Malden

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Records

(Address) /

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9 1917, to Nov 14 1917, that I saw h in alive on Nov 14 1917, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration) yrs. mos. 10 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.

....., 191... (Address) Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. 10 ds. In the State 8 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence South Carolina.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health. ADDRESS

UNIVERSITY OF MARYLAND

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10238 D10238

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 721 W. Lafayette St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zachariah Taylor

(Residence in Baltimore: No. 721 W Lafayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb. 21, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). 045

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robt. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Elizabeth Train

13-BIRTHPLACE OF MOTHER (State or Country) Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rich Taylor

(Address) 721 W Lafayette Ave

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) yrs. mos. ds.

(Signed) H. Wellington M. D.
(Coroner)

....., 191... (Address) 19 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Nov. 23 1917

20-UNDERTAKER John O. Mitchell

ADDRESS 120 W. Fayette St.

D10239 HEALTH DEPARTMENT—CITY OF BALTIMORE D10239

CERTIFICATE OF DEATH.

165

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 Broad alley ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Punte.

(Residence in Baltimore: No. 109 Broad alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) ..... (Day) 1869 (Year)

7-AGE.	If LESS than 1 day,
48 yrs. 10 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 043

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Punte

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Punte

(Address) 2208 Eastern Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental poisoning by swallowing Sulphuric Acid

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Theodore Pyper Brunn (Coroner.) M. D.

Nov 21, 1917. (Address) 1610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart	Nov. 22, 1917
20-UNDERTAKER	ADDRESS
Filby & Zile.	403 W. Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10240 D10240

CERTIFICATE OF DEATH.

REGISTERED No. C 1572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 E Clement ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Cardeau

(Residence in Baltimore: No. 406 E Clement St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 21, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Theodore Cardeau

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bernadett Connolly

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Theodore Cardeau

(Address) 406 E. Clement St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Nov 21 1917, that I saw h-in alive on Nov 21 1917, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Instrumental Delivery
Probably pressure on Heart

.....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) same

.....(Duration)....yrs....mos....ds.

(Signed) Wm C Stuller M. D.

11/21, 191.. (Address) 1319 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Nov 24 191 7.

20-UNDERTAKER John J Taher & Son ADDRESS 1318 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D10241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10241

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Weiss

(Residence in Baltimore: No. 2209 Fulton Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, November 15, 1891.
(Month) (Day) (Year)

7-AGE, 25 yrs. — mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Weinheimer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Augusta ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Nick

(Address) J. H. Hospital

15-

Filed NOV 22 1917, 191.... Registrar.

ROBERT V. KRAUTH
Special Deputy Clerk

L. S. P.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1917, to Nov. 21, 1917, that I saw him alive on Nov. 21, 1917, and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. 6 mos. ds.

(Signed) [illegible] M. D.

Nov. 21, 1917. (Address) John H. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2209 Fulton Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bato Cemetery	Nov. 23, 1917.
20-UNDERTAKER Wm Cook	ADDRESS 502 E. North Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D10242 D10242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 N Montford ave 6 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Bromwell

(Residence in Baltimore: No. 244 N Montford ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, March 3, 1846
(Month) (Day) (Year)

7-AGE, 71 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Christopher Steiner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margareth Engelberth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Bromwell

(Address) 244 N. Montford Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Nov 20 1917, that I saw her alive on Nov 19 1917, and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(Duration) yrs. 4 mos. 20 ds.

CONTRIBUTORY. None known
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph C. Eisenhart M. D.

Nov 21, 1917. (Address) 2201 E. Oakleigh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery.	Nov. 22, 1917.
20-UNDERTAKER	ADDRESS
R. Sander Sons	210 East N.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10213 D10213

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 N. Eden St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisa Reinhardt

(Residence in Baltimore: No. 1038 N. Eden St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Nov 11th, 1849 (Month) (Day) (Year)

7-AGE, 68 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 037
(b) General nature of Industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Killian

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Rinbach

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Tilghman

(Address) 1038 N. Eden St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1917, to Nov 20 1917, that I saw her alive on Nov 20 1917, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Apoplexy

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Aortic Dilatation

Heart (Duration) yrs. suddenly ds.

(Signed) Wm. Thayer M. D.

, 191... (Address) 805 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cem.	Nov. 23, 191.7.
20-UNDERTAKER	ADDRESS
H. Sander Sons	1710 Mct N.

Spec.—8-24-14—M. & T.—2000 Bks.

D10241 D10217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S Fremont St.; 27 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie C Young

(Residence in Baltimore: No. 603 S Fremont St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 22 (Month) (Day), 1875 (Year)

7-AGE, 42 yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard Knights

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Young

(Address) 1509 W Madison

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Nov 21 1917, that I saw h[illegible] alive on Nov 20 1917, and that death occurred, on the date stated above, at 1-10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

.....

.....

Duration: Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

Duration: [illegible] yrs. mos. 3 ds.

(Signed) R. E. Campbell M. D.

Nov 21 1917. (Address) 1509 W Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem DATE OF BURIAL, Nov 24 191.7.

20-UNDERTAKER Frank Leger ADDRESS 1600 W North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10215 D10215

CERTIFICATE OF DEATH.

X53

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Weir.

(Residence in Baltimore: No. 264 S. Bouldin St ST.; 35 yrs., 11 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. 9, 1881
(Month) (Day) (Year)

7-AGE, 35 yrs. 11 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Robert Weir

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Kate Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norah Booth

(Address) 1528 N. Wolfe

15-

Filed ....., 191.....
Registrar.

NOV 22 1917 BUREAU OF STATISTICS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1917, to Nov. 21 1917, that I saw him alive on Nov. 20, 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Lypmphatic Leukemia

dont Know.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 9 ds.

(Signed) J. Edw. Norris, M. D.

11/22/17 191... (Address) St. Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 9 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? don't know

Former or usual residence 264 S. Bouldin St.

19-PLACE OF BURIAL OR REMOVAL, Schwartze — DATE OF BURIAL, Nov. 22, 1917.

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager

D10216

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 ✓ D10216

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2215 Oak St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Albert William Ball

(Residence in Baltimore: No. 2215 Oak St.: —yrs. 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: September 6, 1917 (Month) (Day) (Year)

7 AGE: ..... yrs. 2 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Baltimore - Md.

PARENTS

10 NAME OF FATHER: Oscar William Ball

11 BIRTHPLACE OF FATHER (State or country): Baltimore - Md.

12 MAIDEN NAME OF MOTHER: Gertrude Arment

13 BIRTHPLACE OF MOTHER (State or country): Baltimore - Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar William Ball

(Address) 2215 Oak Street

15.

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 21, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 3, 1917, to November 21 1917, that I saw him alive on November 21, 1917, and that death occurred, on the date stated above, at 8.30 P m.
The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Congenital Lues

(Duration) yrs. mos. ds.

(Signed), Burton C. Lapmon M. D.

Nov. 21, 1917 (Address) 2713 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. in the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn | DATE OF BURIAL: Nov 23, 191

20 UNDERTAKER: Edmonston & Sons | ADDRESS: Baltimore

is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10247

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza E. Phillips

(Residence in Baltimore: No. 3612 Falls Road St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan 13, 1879. (Month) (Day) (Year)

7-AGE, 38 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos. R. Neil

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Emma.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benton E. Phillips

(Address) 3612 Falls Rd

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 191.., to Nov. 12 191.., that I saw h.. alive on Nov. 12 191.., and that death occurred, on the date stated above, at 10.35 a.m.

The CAUSE OF DEATH* was as follows:

.....Sept. Pneumonia.....

.....

.....

.....(Duration) 4 hrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

.....(Duration) 2 hrs. mos. ds.

(Signed) Edward W. Dunn M. D.

Nov. 12, 191.. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. 4 mos. ds.

Where was disease contracted, if not at place of death? 3612 Falls Rd

Former or usual residence 3612 Falls Rd

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden DATE OF BURIAL, Nov. 14, 191..

20-UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10218 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10218

CERTIFICATE OF DEATH.

REGISTERED No. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Crown

(Residence in Baltimore: No. 2409 Elmora Ave St.; ..... yrs.. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) M

6-DATE OF BIRTH. June 22, 1875 (Month) (Day) (Year)

7-AGE. 42 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. C. F. Gunaurtf

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary McKnight

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Crown

(Address) 2409 Elmora Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Nov 20 1917, that I saw h- alive on Nov 19 1917, and that death occurred, on the date stated above, at 2:15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Pulmonary

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest W. Rawson M. D.

Nov 20., 1917. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 2409 Elmora Ave

Former or usual residence 2409 Elmora Ave.

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge DATE OF BURIAL. Nov 22 1917

20-UNDERTAKER J. Fletcher Hopkins ADDRESS Mount

Spec.—8-24-14—M. & T.—2000 Bks.

D10249 HEALTH DEPARTMENT—CITY OF BALTIMORE D10249

CERTIFICATE OF DEATH.

1X

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mathias

(Residence in Baltimore; No. 218 S. East ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 9 (Day), 1907 (Year)

7-AGE, 10 yrs. 3 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frederick Matthias

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rose Hemfelder

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Matthias

(Address) 218 S East Ave

15-

NOV 22 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 21 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1917, to Nov 21 1917, that I saw him alive on Nov 21 191.7, and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever (a)

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 3 ds.

(Signed) Bernard Jacobson M. D.

Nov 21, 191.7 (Address) Hebrew Hos P.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 918 S. East ave

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Nov 23 1917.

20-UNDERTAKER A Herwig & Co

ADDRESS 2008 Eutaw

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10250 D10250

CERTIFICATE OF DEATH.

103 ✓ REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 N Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mariana Keenan

(Residence in Baltimore: No. 1421 N Bond St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feby 2, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Hosp

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, John A Clement

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Mary J Cannon

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A Keenan

(Address) 1421 N Bond

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 20 1917, that I saw her alive on Nov 20 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Asthma, Chronic Bacteria & Cardiac Insufficiency

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bacteria & Cardiac Insufficiency (Duration) 2 yrs. ... mos. ... ds.

(Signed) ... M. D.

Nov 22, 1917. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Cathedral	Nov 22, 1917.
20-UNDERTAKER	ADDRESS
Robt Schumm	1629 Bway

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10251

CERTIFICATE OF DEATH.

39 ✓D10251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital & Cancer Hospital ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Hoffer

(Residence in Baltimore: No. 1700 N. Bond St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 7 June 27 (Month) (Day), 1871 (Year)

7-AGE, 76 yrs. 2 mos. 26 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer): in business

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie M. Hoffer

(Address) 1700 N. Bond St.

15-

Filed NOV 22 1917, 191

ROBERT R. KRAUS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22nd, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Nov 22 1917, that I saw h in alive on Nov 22 1917, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

(a) .....

Pulmonary Tuberculosis 1 yr

Tongue (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) J Wade Thomas M. D.

Nov 22, 1917. (Address) 2780 W. Cans Lane

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER Robb & Turner

ADDRESS 1442 N Broadway

Spec.—5-19-13—M. & T.—500 Bks.

D10252 D10252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Mc Elderry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olivia Stanford

(Residence in Baltimore: No. 1315 Mc Elderry St.; 1 yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED, WIDOW, OR DIVORCED~~ (*Write* the word.) Single

6-DATE OF BIRTH, May 9, 1916.
(Month) (Day) (Year)

7-AGE, 1 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, George Stanford

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Blanche Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Stanford

(Address) 1315 Mc Elderry st

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 19 1917, to November 21 1917, that I saw him alive on Nov 21 1917 and that death occurred, on the date stated above, at 4.45 p m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. mos. 14 ds.

(Signed) Richard J. Eastman M. D.

Nov 22, 1917. (Address) 1514 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Cemetery DATE OF BURIAL, Nov 22, 1917

20-UNDERTAKER P. E. Gross ADDRESS 405 Mc Elderry st

D10253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 ✓ D10253

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam L Ward

(Residence in Baltimore: No. 1021 Hollins St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Married

6-DATE OF BIRTH, Feb (Month) 6 (Day), 1879 (Year)

7-AGE, 38 yrs. 9 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer): Jos Jas Co. 026

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Adam L Ward

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER C Schmansky

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria A Crowe

(Address) 2409 Elm ave

15-

Filed ....., 191.... B. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
Alcoholism

(Duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Exposure & Chill

(Duration) .... yrs. do mos. .... ds.

(Signed) James M Fenlon M. D.
(Coroner.)

Nov 22 1917 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place Franklin Sq Hos in the of death .... yrs. .... mos. .... ds. State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? 1021 Hollins

Former or usual residence 1021 Hollins

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov 23 1917

20-UNDERTAKER W J Fickus & Sons

ADDRESS North & Penn Sts

170

3 30 PM

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 175

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. President & Pratt ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McNamara

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	S

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
21 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): O I S

9-BIRTHPLACE, (State or Country), Washington D. C.

PARENTS.

10-NAME OF FATHER, Thomas McNamara

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER C. Dailey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marten McNamara

(Address) 1121 Robinson St.

15-

NOV 22 1917

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental decapitation run
railroad train

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Ryan Crosby M. D.
(Coroner.)

Nov 22, 191.. (Address) 120 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Washington, D.C.	11/22, 191..
20-UNDERTAKER Henry W. Means & Son	ADDRESS 805 N. Calvert St.

via Penn. R.R. - Ft. Clarence Lot E Sec. -

Spec.—8-24-14—M. & T.—2000 Bks. Elizabeth Josephine Amuzgewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10255 D10255

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Lancaster St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Amuzgewski

(Residence in Baltimore: No. 1813 Lancaster St.; ... yrs., 6 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, ... Nov (Month) 7 (Day) 1911 (Year)

7-AGE, ... yrs. 7 mos. 22 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Amuzgewski

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Lena Pawlak

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Amuzgewski

(Address) 1813 Lancaster St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 22 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Nov 22 1917, that I saw h[illegible] alive on Nov 22 1917, and that death occurred, on the date stated above, at 9:10 A m.

The CAUSE OF DEATH* was as follows:

..... Measles

.....

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Thos. A. Bruchet M. D.

11-22, 1917 (Address) 1621 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St. Stanislaus. | DATE OF BURIAL, Nov 23, 1917.

20-UNDERTAKER W. F. Gadowski | ADDRESS 705 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

DLO256 DLO256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 109 S. Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Shinkman

(Residence in Baltimore: No. 109 S. Stricker St ST.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 10 (Day), 1846 (Year)

7-AGE, 71 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Albert John Koenig

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert G. Shinkman

(Address) 109 S. Stricker St.

15-

NOV 22 1917

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1917, to Nov 22 1917, that I saw her alive on Nov 21 1917, and that death occurred, on the date stated above, at 2.05 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Henry E. Duke M. D.

Nov 22, 1917. (Address) 1203 N. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 26th, 1917.

20-UNDERTAKER, Joseph Cox

ADDRESS 100 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D10257

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 St. Mary ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Smith

(Residence in Baltimore: No. 376 St. Mary St.: ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 5-8 ....yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer). House Wife

9-BIRTHPLACE, (State or Country), Tazewell Co Va

PARENTS.

10-NAME OF FATHER. Joseph Bailey

11-BIRTHPLACE OF FATHER (State or Country). Louisa Va

12-MAIDEN NAME OF MOTHER Rose Bailey

13-BIRTHPLACE OF MOTHER (State or Country). Of Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) by her Son Nelson Hay

(Address) 516 St Mary St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Nov. 21 1917, that I saw her alive on Nov. 21 1917, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

..... (Duration) yrs. mos. ds.

(Signed) Edw. J. Wheeler M. D.

11/22, 1917. (Address) 1230 Division Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Nov 23, 1917

20-UNDERTAKER Wm R A Elliott — ADDRESS 566 Park Av

D10258 HEALTH DEPARTMENT---CITY OF BALTIMORE D10258

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C 79

CITY OF BALTIMORE: (No. 1515 W. 36th St. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bates

(Residence in Baltimore: No. 1515 W. 36th St. St.; 1 Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Sept. 12 (Month) (Day), 1843 (Year)

7-AGE: 74 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Harford Co. Md

PARENTS

10-NAME OF FATHER: Samuel Hopper

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Mary Waters

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Bates

(Address) 1515 W. 36th St

15- NOV 23 1917 ROBERT R. KRAUTER

Filed ....., 191 ..... Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1917, to, Nov 22 1917, that I saw h[illegible] alive on Nov. 22 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease
Mitral regurg & aortic stenosis

about 10 (Duration) yrs mos. ds.

Contributory (SECONDARY) Senility

(Duration) yrs. 3 mos. ds.

(Signed) Denton J Kelly M. D.

Nov. 22 1917. [Address] 3705 Falls Road

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not of place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Mary's Cemetery

DATE OF BURIAL: Nov 24 1917

20-UNDERTAKER: Thorwarth Son

ADDRESS: Celebrated Sure

D10259 HEALTH DEPARTMENT—CITY OF BALTIMORE 182 D10259

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 728 Eutaw Second St St.: 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Edwards
(Residence in Baltimore: No. 728 Eutaw Second St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 21, 1887.
(Month) (Day) (Year)

7-AGE, 30 yrs. 2 mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.
10-NAME OF FATHER, Chas McCamley
11-BIRTHPLACE OF FATHER (State or Country) Mouth Edwards
12-MAIDEN NAME OF MOTHER Kitty
13-BIRTHPLACE OF MOTHER (State or Country). Cuba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Monta McCamley
(Address) 726 Eutaw Second St

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homocidal Shooting

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herman Bryan Duval Cty (Coroner) M. D.

Nov 23, 1917 (Address) 716 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balti Cemetery — DATE OF BURIAL, Nov. 24, 1917.

20-UNDERTAKER E. D. Fanning — ADDRESS 1937 E. Lafayette Ave

E.S.P.

D10260 D10260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospt ST.; 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. A. Howard

(Residence in Baltimore: No. 728 Linde 22 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	White	Married

6-DATE OF BIRTH, ..., 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. / mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas. Howard

11-BIRTHPLACE OF FATHER (State or Country). Richmond Va.

12-MAIDEN NAME OF MOTHER C. Kirby

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm A. Howard
(Address) 15-15 Hillsdale

15-
Filed ....., 191.....
Registrar.

C. S. P.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jul 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounds by pistol shot
wound in brain
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)
Jul 23 1917 (Address) 1629 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet-Cem. DATE OF BURIAL, Nov 24, 17

20-UNDERTAKER F. F. Tahey & Son ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

Millie Ennis

010261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 010261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Wrilet ST.; 23 WARD) REGISTERED NO. C

2-FULL NAME Millie Ennis.

(Residence in Baltimore: No. 118 Wrilet st. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Wd.

6-DATE OF BIRTH, Jan 1 (Month) (Day), 1917 (Year)

7-AGE, 60 yrs. mos. 11 ds. 20

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Maria Jones

13-BIRTHPLACE OF MOTHER (State or Country), Newport News.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Banks

(Address) 118 Wrilet St.

15-

Filed....., 191.....

Registrar.

B.F 8216

C. L. P.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 16 1917, to Nov. 20. 1917, that I saw h or alive on Nov. 20. 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Primary. Nervous breakdown

Immediate- Exhaustion

..... (Duration) ..... yrs. ..... mos. 33 ds.

CONTRIBUTORY (Secondary) ....

..... (Duration) ..... yrs. ..... mos. 33 ds.

(Signed) L P Parham M. D.

....., 191... (Address) 506 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Nov. 23, 191...

20-UNDERTAKER R. L. Parham — ADDRESS 1512 Hanby St

Spec.—8-24-14—M. & T.—2000 Bks.

D10262 HEALTH DEPARTMENT—CITY OF BALTIMORE D10262

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Marshall ST.; 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Andrew Baskin

(Residence in Baltimore: No. 1520 Marshall St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 22 ....., 1917...
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 6 hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Andrew Baskin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Meta Jasper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jasper

(Address) 1520 Marshall

15-

Filed....., 191.....
Registrar.

NOV 23 1917
BUREAU OF VITAL STATISTICS
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1917...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 22 1917, that I saw h[im] alive on Nov 22 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(a) Congenital heart disease

.....

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Neil Stuart M. D.

11/22, 191.7. (Address) 1319 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cem — DATE OF BURIAL, Nov 23, 191.7.

20-UNDERTAKER J. Herring & Co — ADDRESS 2[illegible] Aliceanna

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10263

CERTIFICATE OF DEATH.

51

D10263

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hosp. (St.) 11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard L. Fames.

(Residence in Baltimore: No. —— Mary. Gen. Hosp. St.; — yrs., 1 mo. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 22, 1878
(Month) (Day) (Year)

7-AGE, 39 yrs. 8 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Dallas L. James

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Esther L. Minder

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard L. Winder

(Address) 437 E. 20 st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1917, to Nov 22 1917, that I saw h[illegible] alive on Nov 22 1917, and that death occurred, on the date stated above, at 5 45 p.m.

The CAUSE OF DEATH* was as follows:

Exophthalmus goitre (hyper-thyroidism)

(Duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) yrs. — mos. — ds.

(Signed) [illegible] M. D.

11/22, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 22 ds. In the State yrs. 1 mos. 22 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Matthews Co., Virginia.

19-PLACE OF BURIAL OR REMOVAL, Matthews Court House Va. DATE OF BURIAL, Nov. 23 1917.

20-UNDERTAKER Geo. W. Little ADDRESS 681 W. Fremont Balto

D10261 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

175 D10261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Hoffman

(Residence in Baltimore: No. 1973 Patterson Place St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Divorced

6-DATE OF BIRTH, Oct 29 (Month) 1878 (Day), 1878 (Year)

7-AGE, 38 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, George W. Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Margaret McGee

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Letta Lennartz

(Address) 432 Pinkney Ave

15-

Filed....., 191.....

Registrar.

NOV 22 1917 ROBERT R. KRAUTZ CHIEF CLERK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. L. tibia & fib. l. leg, Said to have
Amputated. occurred by accident
Gan. bacillus Infection ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gangrene 2 wks. (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Daly M. D.
(Coroner.)

Nov 22, 1917. (Address) 1621 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Peters

DATE OF BURIAL, Nov. 26, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 E Nath

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10265

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 E Preston St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E Shipley

(Residence in Baltimore: No. 723 E Preston St.) (If not in Baltimore, write State.) yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 28, 1896 (Month) (Day) (Year)

7-AGE, 21 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Railroad
(b) General nature of industry, business, or establishment in which employed (or employer): Brakeman

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William E Shipley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Anna M Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E Shipley

(Address) 723 E Preston St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st 1917, to Nov 22 1917, that I saw him alive on Nov 22 1917, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) W. W. Brance M. D.

Nov 22, 191 7 (Address) 502 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER William Cook ADDRESS 502 E Preston St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10266 D10266 X120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. J. Heath.

(Residence in Baltimore: No. Pasadena, Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 16, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Heath

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Marie Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur T. Heath. Son

(Address) Pasadena Md

15-

Filed ....., 191.....
Registrar.

ROBERT R. KRAUTH
NOV 23 1917
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21 1917, to Nov. 22 1917, that I saw h[e] alive on Nov. 22 1917, and that death occurred, on the date stated above, at 12.05 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) Paul Kerr M. D.

11/22, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Pasadena Md.

19-PLACE OF BURIAL OR REMOVAL, Magothy Cemetery

DATE OF BURIAL, Nov 24, 1917.

20-UNDERTAKER ARMSTRONG-DENNY CO.

ADDRESS 115 Light St

D10267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10267

CERTIFICATE OF DEATH.

78

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 310 N Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Borns

(Residence in Baltimore: No. 310 N Vincent St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored.	Widow

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Farrell

(Address) 310 N Vincent St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dilatation Heart Sudden

(Duration) yrs. mos. ds.

(Signed) James M Fulton M. D. (Coroner)

Nov 24. 1917 (Address) 2 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 23 1917
20-UNDERTAKER	ADDRESS
Booth & Ford & Schwabert	114 W

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10268 D10268

CERTIFICATE OF DEATH.

89

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2540 Salem St. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Paul Raabe (Radtke)

(Residence in Baltimore: No. 2540 Salem St. St.; — yrs., 6 mos. (2 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 10, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Emil Raabe.

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Gertrude Ridgley

13-BIRTHPLACE OF MOTHER (State or Country), Carroll County, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Raabe

(Address) 2540 Salem St.

15-

Filed NOV 23 1917, 191.. ROBERT P. KRAUSE Burial Permit Clerk

C.P.O. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17. 1917, to Nov 22 1917, that I saw h.. alive on Nov 22 1917, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis Stomach

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm Seabury M. D.

Nov. 22, 1917. (Address) 621 E. Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths FROM VIOLENT CAUSES, state (1) MEANS OF INJURY; AND (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov. 24, 1917.

20-UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson ave

Spec.—8-24-14—M. & T.—2000 Blks.

D10269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10269

CERTIFICATE OF DEATH.

X92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Hannah Tracy

(Residence in Baltimore: No. ..... St.; ..... yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 30 yrs. ..... mos. ..... ds. If LESS than 1 day, Not Known hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Record

(Address) .....

15-

Filed ..... 191.....

ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1917, to Nov 23rd 1917, that I saw h alive on Nov 23rd 1917, and that death occurred, on the date stated above, at 7.15 Am.

The CAUSE OF DEATH* was as follows:

Embolism Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Right Cataract Malignancy

..... (Duration) ..... yrs. ..... mos. 6 ..... ds.

(Signed) Ernest G. Rebeyn M. D.

Nov 23, 1917. (Address) St Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Havre de Grace

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Havre DeGrace

DATE OF BURIAL, Nov 25, 1917

20-UNDERTAKER E & B Earle

ADDRESS 115 E Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10270 41 ✓ D10270

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Barnes Holden

(Residence in Baltimore: No. 1408 McCulloh St.; 70 yrs., 8 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. February (Month) 23 (Day) 1847 (Year)

7-AGE. 70 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Enoch P. Holden

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Elizabeth G. Ijams

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna P. Holden

(Address) 1408 McCulloh

15-

Filed....., 191.....

Registrar. E. S. P.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 24 (Day), 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 191 7, to Nov 24 191 7, that I saw h[er] alive on Nov 24 191 7, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

Bronchial (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 2 mos. ds.

(Signed) Ira L. Fisher M. D.

11/26, 191 7 (Address) 2042 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL, Nov 27, 191 7

20-UNDERTAKER Stewart Warren Co

ADDRESS 108 W. North

D10272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10272

CERTIFICATE OF DEATH.

167

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Maurer

(Residence in Baltimore: No. 518 St Paul St., St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, ..., 1912
(Month) (Day) (Year)

7-AGE, 5 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, John Maurer

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Lizzie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Maurer

(Address) 518 St. Paul St

15-

Filed....., 191.....
Registrar.

NOV 23 1917 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, Generalized
Sepsis
Contracted

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

Nov 22 1917. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Parkton Balto Co. Md. DATE OF BURIAL, Nov 24th 1917

20-UNDERTAKER Chas S. Bailey ADDRESS 1421 Jefferson st

Important. See instructions on Page 2 of Certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10272

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bracker

(Residence in Baltimore: No. Little Sisters of the Poor St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Wid.

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 080

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Backer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Gundy

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

NOV 23 1917 HUNTER R. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22nd, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to ..... 191...,
that I saw h[illegible] alive on 191.7.,
and that death occurred, on the date stated above, at 11.30 a.m.
The CAUSE OF DEATH* was as follows:

.....(a).....
Cause Pneumonia
Paralysis
Duration ..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Bronchial pneumonia
..... (Duration) ..... yrs. few days mos. ..... ds.
(Signed) ..... M. D.
Nov 22, 1917. (Address) 1132 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 3 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Nov 24, 191...
20-UNDERTAKER A. C. Fickey	ADDRESS 214 Dromm Ave

D10273 HEALTH DEPARTMENT—CITY OF BALTIMORE 154 ✓ D10273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 E Hoffman St. 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Murray

(Residence in Baltimore: No. 1007 E Hoffman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... Engineer, B & O

539

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Adolphus

(Address) 1007 E. Hoffman St.

15-

Filed NOV 23 1917, 191.....

ROBERT R. LEDDY Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Nov. (Day) 21, (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Senility .....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... Unk
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)..... (Coroner.) M. D.

Nov. 21, 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Nov. 23, 1917

20-UNDERTAKER A. C. Wakefield — ADDRESS 914 Fremont Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D10271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10271

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Margaret Lentz

(Residence in Baltimore: No. 835 Light St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	single

6-DATE OF BIRTH. August 3, 1917 (Month) (Day) (Year)

7-AGE. yrs. 3 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albright Lentz

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Margaret Mengel

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 16 1917, to Nov. 22 1917, that I saw her alive on November 22 1917, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 3 mos. 19 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) yrs. 3 mos. 19 ds.

(Signed) J. M. Swan M. D.

Nov. 27 191.. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 835 Light St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov. 28, 191...

20-UNDERTAKER Louis Heeman — ADDRESS 32 S. Broadway

D10275

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 ✓ D10275

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1140 Cookesie ST.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine Jungbauer

(Residence in Baltimore: No. 1140 Cookesie St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH Nov. (Month) 4 (Day), 1910 (Year)

7 AGE 7 yrs. mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jungbauer

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Hedwig

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hredenhoft (Mother)

(Address) 1140 Cookesie St

15.

Filed NOV 23 1917, 191 ROBERT B. LAMBDIN Burial Permit Clerk

REGISTRAR

is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. (Month) 20 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1917, to Nov. 20, 1917, that I saw her alive on Nov. 20, 1917, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia
in Both Lungs

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY) Severe Cold

(Duration) yrs. mos. ds.

(Signed) Thos. F. McCormick M. D.

Nov 22, 1917 (Address) 1421 Eastern Place
Same Point of Primary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Cross A.A. Co. DATE OF BURIAL Nov. 23, 1917

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St

Sp...—8-24-14—M. & T.—2000 Bks.

10276

HEALTH DEPARTMENT—CITY OF BALTIMORE

10276

CERTIFICATE OF DEATH.

41

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Milton Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. McGuire

(Residence in Baltimore: No. 528 N. Milton Ave St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	W

6-DATE OF BIRTH, August (Month) 30 (Day), 1856 (Year)

7-AGE.	If LESS than 1 day,
61 yrs. 2 mos. 23 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Wells

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Sard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah A. Dorsett

(Address) 528 N. Milton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 30 1917, to Nov 22 1917, that I saw h.. alive on Nov 22 1917, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

a.....

Carcinoma of Intestines

b.....

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 7 ds.

(Signed) J. Augustus Cheston M. D.

Nov 23, 1917 (Address) 2129 E Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cambridge Dorchester Co. Md. DATE OF BURIAL, Nov 24, 1917.

20-UNDERTAKER Christian Miller ADDRESS 2334 Jefferson St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 118 E Ostend St. WARD) REGISTERED NO. C 150

2-FULL NAME Leo Weyler

(Residence in Baltimore: No. 118 E Ostend St St.; ..... yrs., ... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 11, 1914 (Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Peter Weyler

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Edna Boyle

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Weyler

(Address) 118 E Ostend St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Nov 22 1917, that I saw him alive on Nov 22 1917, and that death occurred, on the date stated above, at 1305 m.

The CAUSE OF DEATH* was as follows:

Congenital Patent Foramen Ovale

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital Heart Lesion

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Jas A O'Donnell M. D.

Nov 26, 1917. (Address) 102 E Mass

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park | DATE OF BURIAL, Nov 24, 1917.

20-UNDERTAKER J Wm Loney & Sons | ADDRESS 1318 Light St.

D10278 HEALTH DEPARTMENT—CITY OF BALTIMORE D10278

CERTIFICATE OF DEATH.

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1-PLACE OF DEATH
CITY OF BALTIMORE (No. 836 E Bond St. St.; 3 WARD) REGISTERED No. C

2-FULL NAME Elizabeth Chmielewski

(Residence in Baltimore: No. 836 E Bond St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 11 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Nov 28 (Month), (Day), 1906 (Year)

7-AGE,	If LESS than 1 day,
yrs. 11 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Chmielewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Michalski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chmielewski

(Address) 836 E. Bond St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pleo Colitis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Thomas Ryan Sus Coy M. D.
(Coroner.)

Nov 27, 1917. (Address) 1620 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Nov 24, 1917.
20-UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D L0270 — 104 — L0270

1 PLACE OF DEATH — 27 N. Carey St.

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Robert Garrett Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Marie Wirth

(Residence in Baltimore: No. 1026 N. Eutaw St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: February 18, 1917 (Month) (Day) (Year)

7-AGE: — yrs. 9 mos. 5 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Herman W. Wirth

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Olive Sterling

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman W. Wirth

(Address) 1026 N. Eutaw

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 23, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 10, 1917, to, November 23 1917, that I saw her alive on November 22 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) — yrs 1 mos. 4 ds.

Contributory (SECONDARY) Bronchitis 3 weeks, Mal-nutrition (Duration) — yrs. 1 mos. 15 ds.

(Signed) ..... M. D.

Nov 23 1917 [Address] 27 N. Carey St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 13 ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Nov 13th 1917

20-UNDERTAKER: Mr & Mrs John W. Imfeld — ADDRESS: 801 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10280 HEALTH DEPARTMENT—CITY OF BALTIMORE D10280

10

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Hoffman ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Nichols

(Residence in Baltimore: No. 207 Hoffman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) 1866 (Day) ..... (Year) 1

7-AGE, 51 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 004

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas. Nichols

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Nancy Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Jones

(Address) 207 Hoffman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21 (Month) (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 191 7, to Nov. 21 191 7, that I saw h alive on Nov. 20 191 7, and that death occurred, on the date stated above, at 6 30/100 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

..... (Duration) 8 yrs. 1 mos. 1 ds.

(Signed) [illegible] M. D.

Nov. 27, 191 7 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Nov. 24, 191 7

20-UNDERTAKER Felix D. Ruck

ADDRESS 1125 Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

10281

HEALTH DEPARTMENT—CITY OF BALTIMORE

10281

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Gallagher

(Residence in Baltimore: No. 2426 Boston St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov (Month) 22 (Day), 1917 (Year)

7-AGE, ——yrs.——mos.——ds. If LESS than 1 day, 20 hrs. or——min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jos. Gallagher

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER Mrs. Josephine Gallagher

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Gallagher

(Address) 2426 Boston St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 23 1917, that I saw h~~im~~ alive on Nov 22 1917, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Premature built 7 months

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ernest W. McQuay M. D.

Nov 23, 1917. (Address) St. Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ——

Former or usual residence ——

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER Chas. Ahearn — ADDRESS 1424 Pine

9.

Spec.—8-24-14—M. & T.—2000 Bks.

D10282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10282

28 ✓ REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N. Castle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. W. Myers

(Residence in Baltimore: No. 1817 N. Castle St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. Dec. (Month) 5 (Day), 1886 (Year)

7-AGE. 31 yrs. 11 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Gen.

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Henry Meyers

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Sophia Mayr

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sophia Walters

(Address) 1817 N. Castle

15-

Filed ....., 191...

..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Nov. 22 1917, that I saw h[illegible] alive on Nov 21 1917, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John G. Myers M. D.

....., 191... (Address) 1603 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Nov 24, 191[illegible]

20-UNDERTAKER E J Canning, 1938 E Lafayette Ave

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D10283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10283

1-PLACE OF DEATH Hebrew Hosp. 14 50 REGISTERED NO. C

CITY OF BALTIMORE: (NO. ..... ST., 14 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Blechman

(Residence in Baltimore: No. 1412 - Madison Ave St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	W.	Widow

6-DATE OF BIRTH, April (Month) 12 (Day) 1861 (Year)

7-AGE, 56 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Samuel Levy

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jos. Seligman

(Address) 1920 Lindenlyre

15-

Filed ....., 191.... Registrar. B.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-20 1917, to 11-23 1917, that I saw h[er] alive on 11-22 1917, and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetic Coma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Galobardes M. D.

11-23, 1917. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Hebrew

Former or usual residence 1412 Madison Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew

DATE OF BURIAL, Nov. 25, 1917

20-UNDERTAKER D. Gondheim

ADDRESS 11 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10281

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 Vine ST.) 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Martin

(Residence in Baltimore: No. 2129 Vine St.; 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb 16, 1840
(Month) (Day) (Year)

7-AGE, 77 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Alexander Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Dinmar

(Address) Catawissa Pa

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1913, to Nov 21 1917, that I saw her alive on Nov 19 1917, and that death occurred, on the date stated above, at 8:40 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(Duration) 1 yrs. mos. ds.

(Signed) Hattie E Kindsvater M. D.

Nov 22, 1917 (Address) 2002 N. Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Nov 24 1917

20-UNDERTAKER William Cook — ADDRESS 507 E North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10285 D10285

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2734 St Paul ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Mohr

(Residence in Baltimore: No. 2734 St Paul St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, Married (*Write* the word.)

6-DATE OF BIRTH, Febru. 7, 1871. (Month) (Day) (Year)

7-AGE, 46 yrs. 9 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John N. Foss

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia Monger

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18th 1917, to Nov 22 1917, that I saw her alive on Nov 21 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Speckmall M. D.

Nov. 23, 1917. (Address) 2112 E. Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov 24, 1917.

20-UNDERTAKER, John D. Mitchell

ADDRESS 1201 W. Pratt St.

Spec.—8-24-14—M. & T.—2000 Blks.

D10286

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

154

D10286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 N. Front ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Carey

(Residence in Baltimore: No. 1039 N. Front St. ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
female	a. a	Widow

6-DATE OF BIRTH, unknown (Month), 1 (Day) (Year)

7-AGE, 64 ? yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Turner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Harriet Turner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Cottis

(Address) 1039 N. Front St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1917, to Nov 22, 1917, that I saw h.er alive on Nov 22, 1917, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Senile Debility

No other cause

(Duration) ....yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Insufficiency Mitr.

(Duration) ....yrs. ? mos. ds.

(Signed) R. K. Elliott M. D.

Nov. 23, 1917. (Address) 152 Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
National Cemetary	Nov. 24, 1917
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	506 Park Ave

D10287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10287

CERTIFICATE OF DEATH.

172

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline M.[illegible] Miller

(Residence in Baltimore: No. Mount St 807 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 36 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Textile worker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, A. McMillen

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ruth. McGee

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. H. Pugh

(Address) 807 N. Mount

15-

Filed Nov 1917, 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Nov. 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
caused by decubitus Fall
or Stair

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture

(Duration) yrs. mos. ds.

(Signed) E. V. Riley M. D.
(Coroner)
Nov 23, 1917 (Address) 16 7 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem
DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER J. Henry & Co
ADDRESS 2108 Allen

11 30

Spec.—8-24-14—M. & T.—2000 Bks.

D10288 HEALTH DEPARTMENT—CITY OF BALTIMORE D10288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Brunt ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Leisle

(Residence in Baltimore: No. 1827 Brunt St.; ....yrs., 1½ mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	White	Single

6-DATE OF BIRTH, ...Aug.... (Month) 4th (Day), 1917 (Year)

7-AGE, ...yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clarence Leisle

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Blanche Davis

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Clarence Leisle

(Address)...1827 Brunt St

15-

Filed....., 191.....

Registrar.

NOV 24 19

ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 191.., to Nov 22 191.., that I saw h.r alive on Nov 22 191.., and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul Brown M. D.

Nov 23, 191.. (Address) 1837 Brunt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Hebron	Nov 24, 191..
20-UNDERTAKER Daniel Carlon	ADDRESS 816 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10289 D10289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Stockton ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberta Bowen

(Residence in Baltimore: No. 506 N. Stockton St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) child

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos.....ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Cyril Bowen

11-BIRTHPLACE OF FATHER (State or Country), va

12-MAIDEN NAME OF MOTHER annie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) annie Bowen

(Address) 506 n. Stockton st

15-

Filed NOV 24 1917, 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 191 7, to Nov 23 191 7, that I saw h[illegible] alive on Nov 23 191 7 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Mitro Colitis

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

11/23/, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mount auburn cemetery

DATE OF BURIAL, Nov 24, 191 7

20-UNDERTAKER John H Toddvin

ADDRESS 43 Hillen st

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10290

CERTIFICATE OF DEATH.

64 D10290

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2504 E. Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lumsden

(Residence in Baltimore: No.) 2504 E. Federal St.; 64 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug. (Month) 23 (Day), 1853 (Year)

7-AGE, 61 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, Robert Lumsden

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Annie Laughlin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Lumsden

(Address) 2504 E. Federal St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1917, to Nov. 23 1917, that I saw him alive on Nov. 23 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 4 ds.

(Signed) Geo. Fuller M. D.

11-24, 1917 (Address) 937 Hugh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov. 26, 1917

20-UNDERTAKER H. Lauder's Sons

ADDRESS 1710 Hoot St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10291 D10291

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2055 Bank ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Heine

(Residence in Baltimore: No. 2055 Bank St.; 47 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept (Month) 2 (Day), 1865 (Year)

7-AGE, 52 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Heinrich Brandes

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wilhelmina Meinecke

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Heine

(Address) 2055 Bank St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 20 1917, to Nov. 21 1917, that I saw h[illegible] alive on Nov. 20 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydrothorax

(Duration) 2 yrs. mos. ds.

(Signed) Geo. L. McClure M. D.

Nov. 24, 191.7 (Address) 6 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Evangelical Cem. DATE OF BURIAL, Nov. 24th, 191.7

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

D10292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10292

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Fleet ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Maseth

(Residence in Baltimore: No. 2213 Fleet St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug. (Month) 19th (Day) 1856 (Year)

7-AGE, 61 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, John L. Maseth

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Traeger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Maseth

(Address) 2213 Fleet St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20th 191., to Nov 23rd 191., that I saw h.. alive on Nov 21 191., and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

1. Tuberculosis Pulmonalis

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 5 yrs. ....mos. ....ds.

(Signed) C. H. Ritter M. D.

Nov 23, 191.. (Address) 1023 N. Patterson Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cem.	Nov 24, 1917
20-UNDERTAKER	**ADDRESS**
H. Sauder Sons	1110 Fleet St

Spec.—8-24-14—M. & T.—2000 Blks.

D10293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D10293

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 Flex St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dyer

(Residence in Baltimore: No. 641 Hart St St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Marr

6-DATE OF BIRTH, Dec 3 (Month) (Day), 1840 (Year)

7-AGE,	If LESS than 1 day,
77 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Dyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa C Fickey

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H Dyer

(Address) 641 Hart St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 22 1917, that I saw h[illegible] alive on Nov 22 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Bastwell M. D.

Nov 23, 1917 (Address) 29 E. St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem

DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER H. Sander Sons

ADDRESS 1710 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1306 Valley (St.; 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Byrne

(Residence in Baltimore: No. 1306 Valley St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 28 (Day), 1917 (Year)

7-AGE, ...yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Laurence J. Byrne

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret A Dillon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margt. Byrne

(Address) 1306 Valley St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17, 1917, to Nov 22 1917, that I saw h[illegible] alive on Nov 22 1917, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary, Cod

(Duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. ...ds.

(Signed) Howard Kroger M. D.

Nov 23, 1917. (Address) 736 S. Bethel Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Nov 24, 1917

20-UNDERTAKER, H. C. Wedefeld

ADDRESS 914 Gruenmount

Dr. Howard Kroger 500 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10295 HEALTH DEPARTMENT—CITY OF BALTIMORE D10295

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Mura ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Welby

(Residence in Baltimore: No. 701 Mura St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 31 (Month) (Day), 1890 (Year)

7-AGE, 27 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Welby

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Butler

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 701 Mura St.

15-

Filed NOV 24 1917, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-20 1917, to 11-23 1917, that I saw h[illegible] alive on 11-21 1917, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11-23 1917, (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER H. C. Wyndfield

ADDRESS 94 Dreer St.

Dec.—8-24-14—M. & T.—2000 Bks.

D10296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10296

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Christian ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius J Klein

(Residence in Baltimore: No. 2123 Christian St

St.: ... (If Yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... May (Month) 3rd (Day) 1917 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 6 mos. 20 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James J Klein

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Louisa Limberg

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... James J Klein

(Address)..... 2123 Christian St.

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Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November (Month) 22 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 21 1917, to Nov 22 1917, that I saw h in alive on Nov 22 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

..... Bronchopneumonia

..... Ills Collateral Deafness

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ....yrs. ....mos. 4 ds.

(Signed) Norbert C Meyer M. D.

Nov 23, 1917. (Address) 2249 Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Lawn	Nov. 24, 1917.
20-UNDERTAKER	ADDRESS
E. Schluraff Son	1937 Kenyon Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D10297

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 28

D10297

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Butler

(Residence in Baltimore: No. Maryland Penitentiary St.; ..... yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH. Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE. 20 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer 046
(b) General nature of industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Jim Butler

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. P. Hanna Warden

(Address) M. D. Penitentiary

15-

Filed ....., 191.....

Registrar.

NOV 24 1917

ROBERT B. KRAUTER

C.S.D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 20 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 26 1916, to November 20 1917, that I saw him alive on November 19 1917, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Endocardium from Chronic diarrhoea due to Chronic Colitis - I.B. Glandular

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. 24 ds.

(Signed) William F. Schwark M. D.

Nov. 20, 1917. (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 1 mos. 6 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Marshall Hall - Md.

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart DATE OF BURIAL. Nov. 26, 1917

20-UNDERTAKER Chas. P. Graul & Son ADDRESS 1101 Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D10298

REGISTERED NO. C 79 D10298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Gough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Angustiyoriak. (Augustyoriak)

(Residence in Baltimore: No. 1913 Gough St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. (Month) 29 (Day), 1873 (Year)

7-AGE, 44 yrs. 1 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Joseph Angustiniak.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Fronie Boniak

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Angustyniak

(Address) 1913 Gough St.

15-

Filed ....., 191....

Registrar.

NOV 24 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7— 1917, to Nov 23 1917, that I saw h— alive on Nov 21— 1917, and that death occurred, on the date stated above, at 305 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Dis- Valvular

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Anasarca

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

Nov 23, 1917. (Address) 125 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 26" ....., 1917.

20-UNDERTAKER W. F. Warbinske ADDRESS 905 E. Monument St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10299 HEALTH DEPARTMENT—CITY OF BALTIMORE D10299

CERTIFICATE OF DEATH.

+30

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Women's Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Pearl Williams (w)

(Residence in Baltimore: No. 504 Harwood ave Town, Baltimore St.; 38 yrs., mos. de.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb. (Month) 4 (Day) 1879 (Year)

7-AGE, 38 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk in Insurance Office
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob F. Williams

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Anna Ireland

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen K. Williams

(Address) 1921 W. Fayette St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1917, to 10:30 am Nov 23 1917, that I saw h- alive on Nov 23 1917, and that death occurred, on the date stated above, at 10 3/4 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. L. Murdoch M. D.

Nov. 23 1917. (Address) Mercantile Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 wks 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 504 Harwood Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Nov 25, 1917
20-UNDERTAKER	ADDRESS
Henry W. Meanor & Son	205 N. Gay St.

3-00—5-19-15—M. & T.—500 Blks.

D10300 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10300

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Baker ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza D. Harris

(Residence in Baltimore: No. 606 Baker st.

St.: 1 yrs. 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem.

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Baby

6-DATE OF BIRTH, Jany. (Month) 13 (Day), 1916 (Year)

7-AGE, 1 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ollie W. Harris

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Cora Slate

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Harris, mother

(Address) 606 Baker St.

15-

Filed NOV 24 1917 191.... ROBERT B. KRAUTER Registrar.

Burial Permit ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1917, to Nov. 22 1917, that I saw her alive on Nov. 20 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal inflammation

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. F. Townsell M. D.

Nov. 22, 1917 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 24, 1917
20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 N Bway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10301 D10301

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 May St.; WARD) 3

2-FULL NAME 1415 Mary St-Chas. Cuthrell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED No. C.....

(Residence in Baltimore: No. 1415 May St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	w. w.	Married

6-DATE OF BIRTH, June 28, (Month) (Day) 1867 (Year)

7-AGE, 50 yrs. 10 mos. 9 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hod-Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): (35

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Charles Cuthrell

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Cuthrell

(Address) 1415 May St.

15-

Filed....., 191.....

Registrar.

ROBERT A. KRAUTZ
NOV 24 1917
BURIAL PERMIT Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1917, to Nov. 20, 1917, that I saw him alive on Nov. 19, 1917, and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows: Acute Pancreatitis

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Catarrh

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) J. K. Bruce M. D.

Nov. 17, 1917. (Address) 1520 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Nov. 24, 1917.
20-UNDERTAKER Joseph A. Farrell	ADDRESS 1317 Division St

D10302

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D10302

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2586 W Fayette St ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannette Wolf.

(Residence in Baltimore: No. ..... St.; 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: June 6, 1835 (Month) (Day) (Year)

7-AGE: 82 yrs. 5 mos. 16 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Ernest Plutzki

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Johannette Schaupp

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Conrad Bernhardt

(Address) 2586 W Fayette St.

15

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 22, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1917, to Nov 23 1917, that I saw h[illegible] alive on Nov 22, 1917, and that death occurred, on the date stated above, at 7.10 P.M.

The CAUSE OF DEATH* was as follows:

Senile degeneration

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Cardiac insufficiency

(Duration) yrs. 4 mos. 7 ds.

(Signed), Roscoe Grossman M. D.

Nov 23, 1917 (Address) 1428 Mary Land Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Western Cem | DATE OF BURIAL: Nov 24, 1917

20-UNDERTAKER: Geo K Gerber | ADDRESS: Balto - Fayette

State CAUSE OF DEATH in plain terms. So that it may be properly classified. It is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10303 105 D10303

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 919 Columbia ave St. 61 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Walters

(Residence in Baltimore: No. 919 Columbia ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): widowed

6-DATE OF BIRTH: ....., 1 (Month) (Day) (Year)

7-AGE: 78 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Jonathan Lainhart

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Sarah E McCall

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [redacted] Jos J Brown

(Address) 919 Columbia ave

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6, 1917, to Nov 22 1917, that I saw h[redacted] alive on [redacted] 27, 1917, and that death occurred, on the date stated above, at 9 8 m.

The CAUSE OF DEATH* was as follows:

Obstruction of Bowel

(Duration) ..... yrs. 3 mos. ..... ds

Contributory (SECONDARY) Haemorrhage of bowel

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm A Clark M. D.

Nov 28, 1917. (Address) 1014 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 24 1917

20-UNDERTAKER: Geo D Gerber — ADDRESS: Balto [illegible]

State CAUSE OF DEATH in plain terms. Do not use technical or abbreviated words. Every item is very important. See instructions on back of certificate.

D10301 D10301

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1004 Harford Ave 10 St.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ann Young

(Residence in Baltimore: No. 1004 N Harford Ave. St.; yrs. mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: November (Month) 19 (Day), 1917 (Year)

7 AGE: ..... yrs. ..... mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry S. Young

11 BIRTHPLACE OF FATHER (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Annie Flanagan

13 BIRTHPLACE OF MOTHER (State or country): Phila., Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Young, Father

(Address) 1004 N Harford Ave.

15

Filed ..... , 191 .....

REGISTRAR

NOV 24 1917 ROBERT R. KRAUSE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1917, to Nov 24 1917, that I saw h— alive on Nov 20, 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:—

Suppuration & Toxaemia
Ovarian & Heart

..... (Duration) ..... yrs. ..... mos. 6 ds

Contributory (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenlon M. D.

Nov 24, 1917 (Address) 710 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Nov. 24, 1917

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH ITEM is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10305 D10305

CERTIFICATE OF DEATH.

REGISTERED No. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert E Smith

(Residence in Baltimore: No. 1706 Mulliken St St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 14, 1913 (Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rhoda Bantam

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A E Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19 1917, to Nov. 23 1917, that I saw h alive on Nov 23 1917, and that death occurred, on the date stated above, at 9 25 a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(Duration) — yrs. — mos. ? ds.

CONTRIBUTORY (Secondary) whooping cough + bronchopneumonia

(Duration) — yrs. — mos. 10 ds.

(Signed) J. M. Rogers M. D.

Nov. 23, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1706 Mulliken St

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemtery DATE OF BURIAL, Nov. 2, 1917.

20-UNDERTAKER Milton Davis ADDRESS 419 N Eden St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61 ✓

011030

REGISTERED NO. C 011030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Erek

(Residence in Baltimore: No. 918 N. Franklin St.; 2 yrs., 7 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 24, 1915 (Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER. Geo Erek

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Josephine Ackerman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Erek

(Address) 918 Franklin St

15-

Filed ..... 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Nov 24 1917, that I saw h[illegible] alive on Nov 24 1917, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis (Epidemic)

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. 4 ds.

(Signed) O. H. Duvall M. D.

Nov 24, 1917 (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov 25, 1917

20-UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119

D10307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Nuttman ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Spencer

(Residence in Baltimore: No. 520 Nuttman St.; .....yrs,, ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	Single

6-DATE OF BIRTH, ... 11 (Month) 22 (Day), 1867 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Rachel Reddy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Spencer

(Address) 522 Nuttman St.

15-

Filed....., 191.....

Registrar.

NOV 25 1917

ROBERT D. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20 191 7, to Nov. 22 191 7, that I saw her alive on Nov. 22 191 7, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

..... Uremia

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) acute nephritis 3

..... (Duration) .....yrs. .....mos. 3 ds.

(Signed) Jno. H. Tomlinson M. D.

Nov. 24 191 7 (Address) 1419 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 25 191 7
20-UNDERTAKER, Samuel J. Hemsley	ADDRESS 678 W Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

D1030S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1030S

CERTIFICATE OF DEATH.

REGISTERED No. C 78

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 15 S. Bond St. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mendle Kremen

(Residence in Baltimore: No. 15 S Bond St ST.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1850 (Year)

7-AGE, 52 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca

(Address) 111 S Bond St

15-

Filed ....., 191.....

Registrar.

H 292

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1916, to Nov 23 1917, that I saw h[illegible] alive on Nov 23 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) H H Baylin M. D.

Nov 24, 1917. (Address) 212 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	Nov 25, 1917
20-UNDERTAKER Jack Levin	ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10300 D10300

CERTIFICATE OF DEATH.

105

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Blake

(Residence in Baltimore: No. 2829 Hampden Ave., St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. March (Month) 3 (Day) 1915 (Year)

7-AGE. 2 yrs. 8 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Wm F Blake

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Fran Reynolds

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Blake

(Address) 2829 Hampden Ave

15-

Filed ....., 191....

Registrar.

NOV 25 1917 ROBERT R. BRADLEY Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Nov 25 1917, that I saw h[illegible] alive on Nov 24 1917, and that death occurred, on the date stated above, at 1.45a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Cerebralis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 5 ds.

(Signed) H Merkel M. D.

, 191... (Address) St. Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State 1 yrs. 8 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2829 Hampden Ave

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov 27, 191 7

20-UNDERTAKER Chenoweth Son

ADDRESS Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

115 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Mc Elderry St. ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Potts

(Residence in Baltimore: No. 2929 Mc Elderry St. St.; 8 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White.	Married

6-DATE OF BIRTH, August 7th (Month) (Day), 1883. (Year)

7-AGE,	If LESS than 1 day,
34 yrs. 3 mos. 16 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 020

9-BIRTHPLACE, (State or Country), England. (Manchester)

PARENTS.

10-NAME OF FATHER, John T. Potts

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Elizabeth Broadbent

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola E. Potts

(Address) 2929 Mc Elderry St.

15-

NOV 25 1917 ROBERT R. KRAETER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 191..., to Nov 23 191..., that I saw h(im) alive on " 23 191..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis (Atrophic)

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Toxic Cardiac Valvular Complication (Acute Fatal)

..... (Duration) ...yrs. ...mos. 6 ds.

(Signed) G.H. Fraser M.D.

11 23, 191... (Address) 264 S. Highland M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
North Cedar Hill Cem. Philadelphia Pa.	Nov. 26th, 191 7.
20-UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S Broadest.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1031F

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Augustine Thumel

(Residence in Baltimore: No. St Michaels Catholic Church Wolfe St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, December 21st, 1859.
(Month) (Day) (Year)

7-AGE, 57 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Assistant Pastor
(b) General nature of industry, business, or estsblishment in which employed (or employer): St. Michaels Church

9-BIRTHPLACE. (State or Country), Martinsburg W. Va.

PARENTS.

10-NAME OF FATHER, Charles A. Thumel.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Wilhelmina Trautman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Thumel.

(Address) 2208 N. Charles St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1917, to Nov 23 1917, that I saw h[illegible] alive on Nov 23 1917, and that death occurred, on the date stated above, at 21 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 23, 1917 (Address) St Jos Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. 2 mos. ..... ds.

Where was disease contracted, if not at place of death? Buffalo N.Y.

Former or usual residence Buffalo N.Y.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Nov. 26, 1917.

20-UNDERTAKER Lilly & Ziehm. ADDRESS 403 E. Preston St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10312

HEALTH DEPARTMENT—CITY OF BALTIMORE 49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1445 Riggs Ave St.; 24 WARD)

REGISTERED NO. C D10312

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Fitzgerald

(Residence in Baltimore: No. 1445 Riggs Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Jan 1, 1846
(Month) (Day) (Year)

7-AGE, 71 yrs. 10 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

27

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Jas Fitzgerald

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER — Pierce

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm J. Fitzgerald

(Address) 1445 Riggs Ave

15-

NOV 25 1917 ROBERT B. KRAUTER Burial Permit Clerk

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1915, to Nov 25 1917, that I saw h— alive on Nov 24 1917, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. 1 ds.

(Signed) Wm Cook M. D.

Nov 26, 1917. (Address) 914 N. Ch.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery

DATE OF BURIAL, Nov 24, 1917.

20-UNDERTAKER E. D. Fanning

ADDRESS 1460 Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D10313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Snow

(Residence in Baltimore: No. 1604 Jackson St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 29 (Day) 1869 (Year)

7-AGE, 48 yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Gow Gas & El Co

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, James Snow

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Barbara Luke

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Eva Snow

(Address) 1604 Jackson

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 23 1917, that I saw him alive on Nov 23 1917, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

..... Septicaemia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ac. Sup. Appendicitis

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Ernest Tully Krieger M. D.

Nov. 23, 191 7 (Address) St. Joseph Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1604 Jackson St

Former or usual residence 1604 Jackson St

19-PLACE OF BURIAL OR REMOVAL Homewell Bedford Pa. DATE OF BURIAL, Nov 26 191 7

20-UNDERTAKER Fred A. Krause ADDRESS 703 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10311 D10311

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L Sullivan

(Residence in Baltimore: No. 1614 Ruxton ave St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, Feb 1. (Month) (Day), 1849 (Year)

7-AGE, 68 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ann Stonebraner

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Sullivan

(Address) 1614 Ruxton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23 (Month) (Day) Friday, 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 191, to Nov 23 1917, that I saw him alive on Nov. 23 1917, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Insuffic: renal (Duration) yrs. 11 mos. ds.

(Signed) O.A. Rexbekmeder M. D.

11/23, 191 7 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Va.

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, Nov. 26, 1917

20-UNDERTAKER John O'Meara — ADDRESS 1201 W. Fayette

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10315

REGISTERED No. C 79 ✓ D10315

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 921 N. Fulton Ave St. 16 WARD)

2 FULL NAME Horace H. Guilford

(Residence in Baltimore: No. 921 N. Fulton Ave St.: 9 yrs. mos. ds.)

* If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept. 30., 1852 (Month) (Day) (Year)

7 AGE: 65 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): B&O. R.R.

9 BIRTHPLACE (State or country): Ky.,

PARENTS

10 NAME OF FATHER: Wm. Guilford

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Charlotte Kirby

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura A. Guilford

(Address) 921 N. Fulton ave

15.

NOV 25 1917 ROBERT R. REAPER

Filed ....., 191.... Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 22nd, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1917, to Nov 22 1916.

that I saw h alive on Nov 22, 1917.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Edward D. London M. D.

Nov 22, 1917 (Address) 750 N. Howard ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Nov. 26., 1917.

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10316 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10316

CERTIFICATE OF DEATH.

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Patterson Park Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noemi Estelle Reyes (Reyes)

(Residence in Baltimore: No. 1333 Patterson Park Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 15 (Day), 1914 (Year)

7-AGE, 3 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: nnl
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, John E Reyes

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Kathrine E Winters

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Reyes

(Address) 1333 N. Patterson Park Ave

15-

Filed....., 191.....

Registrar.

NOV 25 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Nov 24 1917, that I saw h.r alive on Nov 24 1917, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Stenosis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Intubation

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm Lee M. D.

11/24, 191.. (Address) 2247 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem' — DATE OF BURIAL, Nov 25, 1917

20-UNDERTAKER M Leavy Jones — ADDRESS 833 Lemmon Ave

3 P.M.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10317 — 64 ✓ — D10317

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Lamvale ST.; 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francisca Salome Miller

(Residence in Baltimore: No. 1717 Lamvale St. City St.; 2 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, German

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 3rd (Day) 1828 (Year)

7-AGE, 89 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home wife
(b) General nature of industry, business, or establishment in which employed (or employer).

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9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Magin

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Marie Keyser

(Address) Great Niece

15- X

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 24 1917, that I saw her alive on Nov 22, 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

General asthenia
Has been growing
weaker for years.
Uncontainment (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy
(Duration) yrs. mos. 3½ ds.

(Signed) P. S. Baurdeau-Sisco M. D.

Nov 24, 1917 (Address) 1315 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. Nov 26, 1917

20-UNDERTAKER Wilkinson Cook

ADDRESS 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D10315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 N Pulaski ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Gist

(Residence in Baltimore: No. 2013 N Pulaski St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, April 15, 1867
(Month) (Day) (Year)

7-AGE, 50 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Carroll Co

PARENTS.

10-NAME OF FATHER, Thomas Gist

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co

12-MAIDEN NAME OF MOTHER Lydia Sheets

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Elmore R. Gist

(Address) 2013 N. Pulaski St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1- 1916, to Nov 23 1917, that I saw him alive on Nov 23 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis
(b) Cerebral Hemorrhage
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Broncitis Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Rushton M. D.

Nov 24, 1917 (Address) 114 W. Lafayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westminster Md. DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER W. A. Cook ADDRESS 502 E Nath

Via Timonium

Spec.—8-24-14—M. & T.—2000 Bks.

D10319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 ✓ D10319

1-PLACE OF DEATH Franklin Sq. Hosp

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 100 Calhoun ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Kramer-

(Residence in Baltimore: No. 804 W. Barre, St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... Aug (Month) ..... 28 (Day), 1853 (Year)

7-AGE, 64 yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)..... B4 0073

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9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mullan & Kramer

(Address) 804 W. Barre

15-

Filed....., 191.....

Registrar.

NOV 25 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) ..... 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 24 1917, that I saw h in alive on Nov 24 1917, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Shock following gall bladder Operation

..... (Duration) ..... yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) .....

Shock ..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... H. R. Walker ..... M. D.

Nov 24, 1917. (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 804 W. Barre St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Mullan Co

ADDRESS 507 E Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10326 D10320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 5 WARD) 61

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. F. Madison

(Residence in Baltimore: No. 136 N East St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known (Month), 1 (Day), ... (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

3

9-BIRTHPLACE, (State or Country), Not Known

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov 14 1917, that I saw him alive on Nov. 14 1917, and that death occurred, on the date stated above, at 9.05 A m.

The CAUSE OF DEATH* was as follows:

(a) Pneumococcus Pneumonia

(b) acute

..... (Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Smith M. D.

....., 191... (Address) Mercy Hospital,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State Do Not Known yrs. mos. ds.

Where was disease contracted, if not at place of death? 136 N East St

Former or usual residence 136 N East St

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

Morgue

WM. S. WOODALL

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10321 104 D10321

1-PLACE OF DEATH 4 REGISTERED No. C .....

CITY OF BALTIMORE: (No. University Parkway St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mulford

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
White.	Black	

6-DATE OF BIRTH, ... 11 (Month) 13 (Day) 1911 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 6 days ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, John Tittle.

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Madge Mulford

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 11 (Month) 19 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11 13 1911, to 11 19 1911, that I saw h[illegible] alive on 11 19 - 1911, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

..... Cardiac Collapse

.....

..... (Duration).....yrs.....mos.....6.....ds.

CONTRIBUTORY.....Pulmonary Oedema.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....C. W. Douglas.....M. D.

11-19..., 1911. (Address).....University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

NOV 25 1917

5320

Per Wm. F. Hoggall

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10322 D10322

CERTIFICATE OF DEATH.

109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Brookens

(Residence in Baltimore: No. 229 S Dallas St. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1885
(Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unk.

11-BIRTHPLACE OF FATHER (State or Country), Unk.

12-MAIDEN NAME OF MOTHER Unk

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Supt Recvr.

(Address) .....

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 20 1917, that I saw h alive on Nov 20 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Peritoneal Sepsis

Appy OVR

Acute (Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

Nov 23, 1917. (Address) St Jos Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. 7 mos. ds.

Where was disease contracted, if not at place of death? 229 S Dallas St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health, ADDRESS

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NOV 25 1917 JOHNS HOPKINS HOSPITAL NOV 21 1917

GODALL.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10323

CERTIFICATE OF DEATH.

151 ✓ D10323

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Carlton

(Residence in Baltimore: No. 431 E. Lanvale St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Louis Carlton

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Stella

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 20 1917, to Nov 21 1917, that I saw h[er] alive on Nov 21 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Nov. 22, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 431 E Lanvale St

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

JOHNS HOPKINS HOSPITAL NOV 23 1917

Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10321 D10321

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 N. Spring ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse H. Mitchell

(Residence in Baltimore: No. 1306 N Spring St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colord	Single

6-DATE OF BIRTH, Oct 1 (Month) / (Day) 1914 (Year)

7-AGE, 3 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Walter Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Carrie Watts

13-BIRTHPLACE OF MOTHER (State or Country), Charlotte Hill, N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Carrie Mitchell

(Address) 1306 N Spring St

15-

Filed....., 191.....

Registrar.

NOV 25 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1917, to Nov. 24, 1917, that I saw him alive on Nov. 23, 1917, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

..... (Duration) ~ yrs. ~ mos. 6 ds.

CONTRIBUTORY ~
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin R. Fenby, M. D.

Nov. 24, 1917. (Address) 1223 N. Carlton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	November 26, 1917

20-UNDERTAKER	ADDRESS
Mrs R A Elliott	606 East

Spec.—5-19-13—M. & T.—500 Blks.

D10325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10325

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Mulliken ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Johnson

(Residence in Baltimore: No. 1636 Mulliken St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, June 19, 1857 (Month) (Day) (Year)

7-AGE, 30 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver for contractor
(b) General nature of industry, business, or establishment in which employed (or employer)..... on building

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Henry Johnson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Caroline Staley

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Annie Johnson

(Address)....1636 Mulliken St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 19 1917, to November 23 1917, that I saw h im alive on Nov 23 191 7, and that death occurred, on the date stated above, at 11 o'clock m.

The CAUSE OF DEATH* was as follows:

(a).....Lobar Pneumonia

.....

..... (Duration)....yrs....mos. 6 ds.

CONTRIBUTORY (Secondary).....

..... (Duration)....yrs....mos....ds.

(Signed) Richard H. Easley M. D.

....., 191... (Address) 1514 S. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Nov 26, 1917

20-UNDERTAKER Mrs. R. A. E. Heath

ADDRESS 506 East St

Spec.—8-24-14—M. & T.—2000 Blks.

D10326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10326

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3752 Old Frederick Road ST.; 19th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth C. Manial (Mansal

(Residence in Baltimore: No. 3752 Old Frederick Road St.; 53 yrs. 7 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 8 (Day), 1864 (Year)

7-AGE, 53 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Catonsville Md.

PARENTS.

10-NAME OF FATHER, John Kaestner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mentzel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas C. Manial Jr.

(Address) 3752 Old Frederick Road

15-

NOV 25 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1917, to November 22 1917, that I saw h[illegible] alive on November 19 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis of the intestines

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) H. A. T. H. [illegible] M. D.

Nov 23, 1917. (Address) 2426 Linkard Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 26 1917.

20-UNDERTAKER Robt Timmons — ADDRESS 1424 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10327

CERTIFICATE OF DEATH.

91 ✓

D10327

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 S Castle ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A Welsh

(Residence in Baltimore: No. 228 S Castle St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. Dec 17th, 1916
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 7 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John J Welsh

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Bessie Stone

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J Welsh

(Address) 228 S Castle

15-

NOV 25 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 30 1917, to Nov. 24 1917, that I saw him alive on Nov. 23 1917, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary (Duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 26 ds.

(Signed) Leo Hiller M. D.

11-25-, 191.7 (Address) 1937 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Nov. 26, 191.7

20-UNDERTAKER John A Howard

ADDRESS 13 Bank & Ann Sts

D10328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D10328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Madison ave ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myra Harris

(Residence in Baltimore: No. 930 Madison ave St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May 4th, 1837. (Month) (Day) (Year)

7-AGE, about 80 yrs. 6 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home 070
(b) General nature of industry, business, or establishment in which employed (or employer): Servant

9-BIRTHPLACE, (State or Country), Down Del

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Grace Whitt

(Address) 930 Madison Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191 7, to Nov 24 191 7, that I saw h[er] alive on Nov 23 191 7, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. V. Wallace M. D.

Nov 24, 1917 (Address) Prospect

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Nov 26, 1917.

20-UNDERTAKER Graham F. Walker

ADDRESS 1734 W Fay ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D10329

CERTIFICATE OF DEATH.

64 D10329

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 E. Oliver ST.; 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Jane Cumming

(Residence in Baltimore: No. 1710 E Oliver St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, January (Month) 15th (Day), 1845 (Year)

7-AGE, 72 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Drover

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Eliza Basor

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary G Miller

(Address) 1710 E. Oliver St

15-

Filed ....., 191.... Registrar.

NOV 25 1917 ROBERT R. CRAUTEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24 (Month) (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1917, to Nov 24 1917, that I saw her alive on Nov 23 1917, and that death occurred, on the date stated above, at 12.45 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) C. F. Whitney M. D.

Nov 25, 1917. (Address) 1711 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov 26, 1917

20-UNDERTAKER H E Stephens

ADDRESS 17 S Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10330

CERTIFICATE OF DEATH.

19 ✓

D10330

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Mordecai Bush

(Residence in Baltimore: No. 512 N. Chester St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, June (Month) 20 (Day), 1852 (Year)

7-AGE, 65 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Potter
(b) General nature of industry, business, or establishment in which employed (or employer): 086

349

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, J. H. C. J. Bush

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ann Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Bush

(Address) 512 N. Chester St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 23 (Day), 1917 (Year).

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2 1917, to Nov 23 1917, that I saw him alive on " " 191", and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 3 mos. 21 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease about 4 (four) yrs.

(Duration) yrs. mos. ds.

(Signed) H. Hollenberg M. D.

Nov. 25, 191 7 (Address) 1810 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov. 24, 191 7

20-UNDERTAKER H. E. Snyder

ADDRESS 5 Broadway

D10331 D10331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 Watson ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufin Achen

(Residence in Baltimore: No. 1007 Watson St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 43 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Express
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Rufin Schen

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Schen

(Address) 1007 Watson St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to h— death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] (Coroner.) M. D.

Nov 25, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1007 Watson St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Henning Run — DATE OF BURIAL, Nov. 26, 1917

20-UNDERTAKER Max Linnson — ADDRESS 1107 E Balto St

Sec. 5 of Act of 1898 requires that all of the items of this certificate be properly answered. Failure to do so is a misdemeanor. See instructions on back of certificate. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20 are important.

Spec.—8-24-14—M. & T.—2000 Bks.

D10332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Patterson Place 8 WARD)

REGISTERED No. C 1320

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Klausing

(Residence in Baltimore: No. 1908 Patterson Place St., Lbs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE,~~ MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 23, 1

(Month) (Day) (Year)

7-AGE, 72 yrs. 1 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

43 046

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Herman Klausing

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Klausing

(Address) 1908 Patterson Place

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1917

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Nov 24 1917, that I saw h[im] alive on Nov 23 1917, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

1 Interstitial Nephritis

.....

..... (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) yrs. mos. 2 ds.

(Signed) J. E. Patterson M. D.

Nov 25 1917 (Address) 2213 Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, ~~Loudon Park~~ National Cemetery

DATE OF BURIAL, Nov 27, 191...

20-UNDERTAKER W. M. Cook

ADDRESS 502 Nath

D10333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 640 ST.: Lakesbury WARD) 9 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Juana Anna Fitzerald

(Residence in Baltimore: No. 640 Lakesbury St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) child

6-DATE OF BIRTH, Mar 22, 1913, 1913
(Month) (Day) (Year)

7-AGE, 4 years ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Memphis Tenn.

PARENTS.

10-NAME OF FATHER, Jeremiah Fitzerald

11-BIRTHPLACE OF FATHER (State or Country), Canton Pa.

12-MAIDEN NAME OF MOTHER Louella N. Williams

13-BIRTHPLACE OF MOTHER (State or Country), Morris Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jeremiah Fitzerald

(Address) 640 Lakesbury st

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 23, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock
Burns by Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Mar 23, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Mar 26, 19..

20-UNDERTAKER Wm Cook. — ADDRESS 502 E. Math

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

D10331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10331

CERTIFICATE OF DEATH.

REGISTERED No. C ....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Pronounced dead at Franklin Square Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Guy La Mar

(Residence in Baltimore: No. 2919 Clifton ave St.: 11 yrs., 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
mal	white	Single

6-DATE OF BIRTH. May (Month) 12 (Day), 1906 (Year)

7-AGE. 11 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Boy
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert G. La Mar Sr.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ada Day

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert G. La Mar Sr
(Address) 2919 Clifton ave

15-
Filed ....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Base of Skull
by Collision with Auto—
Mobile accidental
(Duration) ... yrs. ... mos. 1/2 hr
CONTRIBUTORY (Secondary) Hemorrhage into
Brain (Duration) ... yrs. ... mos. 1/2 hr

(Signed) James M. Fenton Jr M. D.
(Coroner.)
Nov 25 191 7 (Address) 700 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death? ....
Former or usual residence 2919 Clifton ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Frederick Md.	Nov 26 1917
20-UNDERTAKER Joseph B. Cole	ADDRESS 100 S Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 26 1917 Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D10335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D10335

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 E Gittings ST.; 24 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E Brewer

(Residence in Baltimore: No. 539 E Gittings St.; yrs., 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 17th, 1911.
(Month) (Day) (Year)

7-AGE, yrs. 5 mos. 7 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas E Brewer

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Susie Trader

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Brewer

(Address) 539 E Gittings

15-

Filed ....., 191.....

Registrar.

NOV 26 1917 ROBERT R. CRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24, 1917.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 24 1917, that I saw h[illegible] alive on Nov 24 1917, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) Barnes H Street M. D.

Nov 24, 191 7. (Address) 1431 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Nov 26, 191 7.

20-UNDERTAKER M. J. Flynn

ADDRESS 1422 Light

Important—See instructions on back of certificate.

D10336

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10336

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No 41 E Hamburg ST. Caldwell 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Henriette Coldwell

(Residence in Baltimore: No. 41 E. Hamburg St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Married

6-DATE OF BIRTH: August (Month) ? (Day) 1888 (Year)

7-AGE: 29 yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs., or ....min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: domestic .03
(b) General nature of industry, business, or establishment in which employed (or employer): House work

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: August Hildt

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Matilda Miller

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Hildt

(Address) 254 S Chapel St

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May – , 1917, to, November 22 1917, that I saw h.... alive on Nov 22 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs ....mos. ....ds.

Contributory (SECONDARY) Pulmonary Tuberculosis

(Duration) 5 Mo yrs ....mos. ....ds.

(Signed) G T Burton M. D.

11-24 1917 [Address] 306 E. Eutaw St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL: Nov 26 1917

20-UNDERTAKER: M. L. Flynn ADDRESS: 1422 Eutaw St.

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10337

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mera ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Funk

(Residence in Baltimore: No. 1135 Riverside Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 1 (Day) ..... (Year)

7-AGE, 54 yrs. 5 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Bottler Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Funk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Miller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Funk

(Address) 1135 Riverside

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Nov 25 1917, that I saw him alive on Nov 20 1917, and that death occurred, on the date stated above, at 6.35 pm.

The CAUSE OF DEATH* was as follows:

Angina Pectoris & Myocarditis

..... (Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Edward J. Funk M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Nov 27, 191.7

20-UNDERTAKER M. J. Flynn

ADDRESS 1422 Light

Important—See instructions on back of certificate.

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D10328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10338

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 420 N. Gmm ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Osburn

(Residence in Baltimore: No. 420 N. Gmm St.: yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Mgh.

6-DATE OF BIRTH. Unknown (Month), (Day), 1877 (Year)

7-AGE. 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Hamm
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). New York

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Pneumonia Lobar

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Quitell M. D.
(Coroner)

Nov 28, 1917. (Address) 211 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER John J. Howard & Son — ADDRESS 1 of Holliday

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10339

CERTIFICATE OF DEATH.

8

D10339

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Fulton Ave. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Campbell

(Residence in Baltimore: No. 613 N. Fulton Ave. St.; 1 yrs., 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. June 16th 1916
(Month) (Day) (Year)

7-AGE. 1 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Harry A. Campbell

11-BIRTHPLACE OF FATHER (State or Country). Ohio

12-MAIDEN NAME OF MOTHER Catherine F. Winter

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Harry A Campbell

(Address) 613 N Fulton St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Nov 24 1917, that I saw her alive on Nov 24 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Pertussis

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Pertussis ? Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Ed Davies M. D.

Nov 28 1917. (Address) 912 N Dunstan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Nov 26th 1917

20-UNDERTAKER John J. Conaway Sons ADDRESS 901 Hollins St.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 blks.

D10340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9r D10340

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 S Paca ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank H Freeman

(Residence in Baltimore: No. 833 S. Paca, St.; 43 yrs., 1 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. October 10th (Month) (Day), 1874 (Year)

7-AGE. 43 yrs. 1 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James H. Freeman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Baudwitte

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Freeman

(Address) 833 S Paca St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 191 7, to Nov 23 191 7, that I saw h[illegible] alive on Nov 23 191 7, and that death occurred, on the date stated above, at 1150 m. A m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. ds.

(Signed) W. C. Swinegar M. D.

11 23, 191 7 (Address) 682 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden

DATE OF BURIAL, Nov 26th, 191 7.

20-UNDERTAKER John F Cowan Son

ADDRESS 907 Hollins St.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W. York St 22 ST.; WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Black

(Residence in Baltimore: No. 105 W. York St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1843 (Year)

7-AGE,	If LESS than 1 day,
74 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 610

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clark Black

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E. Tinsar

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clark Black

(Address) 106 W. York St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 15 1917, to Nov 24 1917, that I saw her alive on Nov 23 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mammae

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Gilchrist M. D.

Nov 25, 1917. (Address) 52 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Nov 26, 1917

20-UNDERTAKER	ADDRESS
M. Doyle & Son	36 N. Eutaw St

Important. See instructions on back of certificate.

ROBERT E. KRAUTH
Burial Permit

5

D10342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10342

CERTIFICATE OF DEATH.

151

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 710 S. Bond ST. 3 WARD)

2-FULL NAME Joseph Drenkowski

(Residence in Baltimore: No. 710 S Bond St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Oct 5 1917
(Month) (Day) (Year)

7-AGE, ..yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Anthony Drenkowski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna Dryka

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Drenkowski

(Address) 710 S. Bond St

15-

Filed....., 191....

Registrar.

8

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..yrs. ..mos. ..ds.

(Signed) Clarence Agnew Coroner M. D.

11/26, 191.7 (Address) 611 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov 26 1917

20-UNDERTAKER Wm Frad Rourke — ADDRESS 1118 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D10343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10343

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Parrish ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Johannes

(Residence in Baltimore: No. 1102 Parrish ave St.; 50 yrs,. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 18 (Day), 1867 (Year)

7-AGE, 79 yrs. 7 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Dulnick

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Johannes

(Address) 1102 Parrish al

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1917, to Nov 1917, that I saw her alive on May 29 1917, and that death occurred, on the date stated above, at 11 55 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) C R Davis M. D.

Nov 26, 191 7 (Address) 926 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State ... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, German Cath Cemt

DATE OF BURIAL, Nov 27, 191 7

20-UNDERTAKER Isaiah Seper

ADDRESS 1600 W North ave

ROBERT R. KRAUTER
NOV 26 1917
BURIAL PERMIT CLERK

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10311

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Wilkins Ave ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis A Bomberger

(Residence in Baltimore: No. 2104 Wilkins Ave St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, May (Month) 12 (Day), 1853 (Year)

7-AGE, 64 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Comerberger

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Virginia Berry

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G E Schaffer

(Address) 2104 Wilkins Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Nov 24 1917, that I saw h[illegible] alive on Nov 24 1917, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 2½ hrs

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D Ed Stultz M. D.

Nov 24 1917. (Address) Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL NOV 27 1917

20-UNDERTAKER Leo A. Gerber

ADDRESS Balto & Hanover Sts

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Stella Walker

(Residence in Baltimore: No. 607 Walnut ave Regnl Heights St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1886 (Year)

7-AGE,	If LESS than 1 day,
32 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Fisher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katherine Stra

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Chas Walker

(Address) 607 Walnut ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23rd Friday, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 13 1917, to Nov 23 1917, that I saw her alive on November 23 1917, and that death occurred, on the date stated above, at 4.25 Pm.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis Meningitis

..... (Duration) ..... yrs. ..... mos. 12 ds.

(Signed) ..... M. D.

11/23 191.. (Address) Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State 32 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 607 - Walnut ave

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, NOV 26 191..

20-UNDERTAKER Geo A Gerber — ADDRESS Baltimore

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10346

CERTIFICATE OF DEATH.

10

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Edmondson Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Eve Krantz

(Residence in Baltimore: No. 1904 Edmondson Ave St.; 60 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 14 (Day) 1831 (Year)

7-AGE, 86 yrs. 7 mos. 9 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John A Krantz

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Everhart

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Fannie Hoff

(Address) 1110 N Fulton Ave

15-

Filed....., 191.....

Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 24 (Day) 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 191 7, to Nov 24 191 7, that I saw h Ex alive on Nov 24 191 7, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Howard Kelly M. D.

Nov 24, 191 7 (Address) 207 W Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Green Mount Cemetery | DATE OF BURIAL. Nov 25, 191 7.

20-UNDERTAKER Stewart & Company | ADDRESS 1518 W. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D1037 D1037

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Lemmon ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Houston

(Residence in Baltimore: No. 1313 Lemmon St.; 0 yrs., 0 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, November (Month) 23 (Day), 1917 (Year)

7-AGE, 0 yrs. 0 mos. 1 ds. If LESS than 1 day, 23 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph Houston

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Ada Furchen

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Houston

(Address) 1313 Lemmon St.

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1917, to Nov. 25 1917, that I saw him alive on November 25 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ... yrs. ... mos. ... ds.

(Signed) L. H. Douglas M. D.

Nov. 25, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudel Cemetery DATE OF BURIAL, Nov 26, 1917.

20-UNDERTAKER R. C. Gross ADDRESS 1405 McElderry

important. See instructions on back of certificate.

Norris

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1310 N. Bremt ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Flora Norris,

(Residence in Baltimore: No. 1310 N. Bremt St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Widowed

6-DATE OF BIRTH, ... Autumn ....., 1870
(Month) (Day) (Year)

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Unknown

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Autumn

11-BIRTHPLACE OF FATHER (State or Country), " Md

12-MAIDEN NAME OF MOTHER Autumn

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ford N. Norris

(Address) 310 N. Bremt St

15-

NOV 26 1917 ROBERT R. BEAUTER

Filed....., 191..... Registrar.

8

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 20 ....., 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)

.....find that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) O.D. Epilepsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

24, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Nov 24, 1917

20-UNDERTAKER	ADDRESS
Charles R. Jones	235 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

D10340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10319

CERTIFICATE OF DEATH.

109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Parker.

(Residence in Baltimore: No. 706½ W Franklin St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1892 (Year)

7-AGE, 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Chas Bell

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital

(Address) Greene & Lombard

15-

Filed ....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/9 1917, to 11/24 1917, that I saw her alive on 11/24 1917, and that death occurred, on the date stated above, at 9:15 p m.

The CAUSE OF DEATH* was as follows:

General Septicaemia

.....

.....

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

..... (Duration) 2 yrs. ..... mos. 21 ds.

(Signed) C. A. Terpenning M. D.

11/25, 1917 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 15 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? former residence

Former or usual residence 706½ W Franklin

19-PLACE OF BURIAL OR REMOVAL. Laurel Leeds

DATE OF BURIAL. Nov. 28, 1917.

20-UNDERTAKER. Charles B. Jones

ADDRESS 235 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10350 41 ✓ D10350

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S. Wolfe ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice E. Riegel

(Residence in Baltimore: No. 321 S Wolfe St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 22, 1871.
(Month) (Day) (Year)

7-AGE, 46 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Wm Cassidy

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary E. McLaughlin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Riegel

(Address) 321 S. Wolfe st.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8 1917, to Nov 24 1917, that I saw her alive on Nov 24 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Exhaustion. Microscopic Exam.

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

Exhaustion (Duration) yrs. mos. 3 ds.

(Signed) J. Wade M. D.

Nov. 24 1917. (Address) 118 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Nov. 27, 1917.

20-UNDERTAKER Wm. E. Block ADDRESS 927 N. Broadway

important. See instructions on back of certificate.

8

Spec.—8-24-14—M. & T.—2000 Bks.

D10367

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Burrell

(Residence in Baltimore: No. 316 W. 28th St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 26, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Charles Burrell

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Virginia Jones

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19 1917 to Nov 23 1917, that I saw her alive on November 22 1917, and that death occurred, on the date stated above, at 2.55 p m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion, acute.

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia, acute

(Duration) — yrs. — mos. 4 ds.

(Signed) J. M. Boston M. D.

Nov 23, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 316 W 28th St

19-PLACE OF BURIAL OR REMOVAL, Sawtelle, Cemetery DATE OF BURIAL, ..., 191..

20-UNDERTAKER Samuel T. Hensley ADDRESS [redacted]

important. See instructions on back of certificate.

D10352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10352

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2223 Eden ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Jorgen

(Residence in Baltimore: No. 2223 Eden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col	Widow

6-DATE OF BIRTH, ..., 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): work 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jorgen

(Address) 2223 Eden Alley

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.
(Coroner.)

June 24, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	June 26th, 19.14
20-UNDERTAKER	ADDRESS
Joseph A Farrell	2-317 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Kaufman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10353 D10353

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 S Ann ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav Jas & Agnes Kaufman

(Residence in Baltimore: No. 507 S. Ann St.; yrs., mos. ds.)

9 24

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W hite	Single

6-DATE OF BIRTH, 11 (Month) 24 (Day) 1917 (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 9 hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer): 080

080

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Kaufman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Agnes Schaf

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Kaufman

(Address) 507 S Ann St.

15-

Filed 2, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-24 1917, to 11-25 1917, that I saw him alive on 11-24 1917, and that death occurred, on the date stated above, at A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos D Dulley M. D.

11-25, 1917 (Address) 162 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, 11-26, 1917

20-UNDERTAKER W. F. Sadowski ADDRESS 905 S Ann

important. See instructions on back of certificate.

NOV 26 1917 Registrar of Vital Statistics Clerk

8

Spec.—8-24-14—M. & T.—2000 Bks.

D10351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10351

CERTIFICATE OF DEATH.

REGISTERED NO. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Nelson

(Residence in Baltimore: No. 1628 N Gay St.; ....yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, June 10, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. 10 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Dr.

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Geo. W. Nelson

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Eliza Miles

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Nelson

(Address) 1628 N. Gay

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1917, to Nov 25 1917, that I saw him alive on Nov 24th 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Decompensation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

Operation (Duration) yrs. mos. 4 ds.

(Signed) M. J. Egan M. D.

Nov 25, 1917. (Address) 411 W. Hoff

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State 3 miles 67 yrs. mos. ds.

Where was disease contracted, if not at place of death? Ball

Former or usual residence 1628 N Gay St.

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Nov 27, 191..

20-UNDERTAKER Robt. Schuster

ADDRESS 1742 N Gay

important. See instructions on back of certificate.

8

Spec.—8-24-14—M. & T.—2000 Bks.

D10355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home 6 + 41 ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Clara Finn.

(Residence in Baltimore: No. Church Home & Inf. St.; yrs. 2 mos. + ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	W	Married

6-DATE OF BIRTH, August 21, 1840
(Month) (Day) (Year)

7-AGE, 47 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Albany, NY

PARENTS.

10-NAME OF FATHER, Orrin Pancoast

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Grelle

(Address) Church Home

15-

Filed....., 191.....
Registrar.

NOV 25 1917 ROBERT B. KNAUER Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Nov. 25 1917, that I saw her alive on Nov. 25 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Colon.

Mucoscopic Exam (Duration) yrs. 2 mos. + ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) H. H. Hamman M. D.

Nov 25, 1917 (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State ? yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 135 Railroad St, Cortland N.Y.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cortland NY	Nov. 26 1917
20-UNDERTAKER	ADDRESS
Ralph D. Turner	1429 Pm

important. See instructions on back of certificate.

8

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10356 D10356

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Smith

(Residence in Baltimore: No. Bergies Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) S

6-DATE OF BIRTH, Nov. 23, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 18 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jos. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Augusta Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Smith

(Address) Bergies Md.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Nov 24 1917, that I saw h[illegible] alive on Nov 24 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature birth 5 hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov 25, 1917. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? St. Joseph's Hospital

Former or usual residence Bergies Md.

19-PLACE OF BURIAL OR REMOVAL, Zion Lutheran Cemetery

DATE OF BURIAL, Nov. 26th, 191.7.

20-UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fullerton Md.

important. See instructions on back of certificate.

K

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 N Patterson Pk Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Meyers

(Residence in Baltimore: No. 443 N Patterson Pk Ave St.; ..... yrs., 4 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	

6-DATE OF BIRTH, July (Month) 8 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 4 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or estsblishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Meyers

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER Margaret Connelly

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 23 1917, to Nov. 24 1917, that I saw h~~e~~ alive on November 24 1917, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

(a) Bronchio Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY, (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J Cook M. D.

Nov 25, 191.. (Address) 1734 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

NOV 26 1917 ROBERT B. KRAUTH Burial Permit Commissioner Health

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10359 D10359

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH West End maternity.

REGISTERED NO. C

CITY OF BALTIMORE: (No. 112 N Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby stittmeri

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	X

6-DATE OF BIRTH, nov 24 (Month) 1917 (Year), 1 (Day)

7-AGE, 8 hrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), West End Maternity

PARENTS.

10-NAME OF FATHER, John Stittmeri

11-BIRTHPLACE OF FATHER (State or Country), Baltimore md

12-MAIDEN NAME OF MOTHER Amelia Wilson.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Turnenphorough M. D.

(Address) West End Maternity

15-

Filed Nov 24, 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, nov 24 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 , that I saw h imalive on Nov. 24 1917, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Turnenphorough M. D.

Nov 24 1917 (Address) West End Maternity

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2575 W. Balto st.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

important. See instructions on back of certificate.

15822

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

P 10359 — 28 ✓ — REGISTERED No. C 10359

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 968 N. Howard St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary LeBaron Theobald

(Residence in Baltimore: No. 968 N. Howard St.; 2 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6-DATE OF BIRTH July 25th, 1892 (Month) (Day) (Year)

7-AGE 25 yrs. 4 mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Samuel Theobald

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Caroline E. Wolf

13-BIRTHPLACE OF MOTHER (State or country): R. I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Samuel Theobald

(Address) 968 N. Howard St.

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November 25, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1, 1917, to November 25 1917, that I saw h[er] alive on November 23, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) ..... yrs. 7 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Laura Hampson M. D.

Nov 26, 1917 (Address) 714 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 27th, 1917

20-UNDERTAKER Henry W. Jenkins Sons Co. ADDRESS McCulloh & Eutaw

This case was investigated by me through Dr. Driscoll and found to have been a clear death from Valvular Heart Disease. The explantion was this woman was cooking on gas stove and had fallen to the floor after which the food on the stove had caught fire and there was no evidence of gas fumes.

Statistician.

H. A. Moore

D10360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10360

79

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 645 W Franklin ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Bowyer.

(Residence in Baltimore: No. 645 W Franklin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH. ....., 1 .....
(Month) (Day) (Year)

7-AGE. 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bedford Pa

PARENTS.

10-NAME OF FATHER, Clarence Bowyer

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER Henrietta Mercer

13-BIRTHPLACE OF MOTHER (State or Country), Bedford Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Clarence Bowyer

(Address) 2609 Floyd Ave

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Driscoll M. D.
(Coroner.)

Nov 26, 191.. (Address) 721 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bedford Cem Bedford Pa | DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER, Wm J. Cowan Son | ADDRESS 701 Harlem

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10361 HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D10361

REGISTERED NO. C.....

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Cleveland ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary ~~Leipzig~~ Olga Watkins

(Residence in Baltimore: No. 2212 Clifton Ave St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, December 7, 1889
(Month) (Day) (Year)

7-AGE, 27 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Julius Leipzig

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Rohde

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Watkins

(Address) 2212 Clifton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Nov 24 1917, that I saw h~~er~~ alive on Nov 24 1917, and that death occurred, on the date stated above, at 12. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculosis

..... (Duration) ....yrs. 10 mos. 24 ds.

(Signed) E. Miles Wheeler M. D.

Nov 24, 1917. (Address) 2129 N. Monthan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery | DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER Mrs Mrs John M. Lenfel | ADDRESS 801 W. Fayette

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10362

50

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Aprt. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Skutch,

(Residence in Baltimore: No. Linden Ave. Park Drive, St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH, Oct. (Month) 10th. (Day) 1850 (Year)

7-AGE, 67 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired. 045
(b) General nature of industry, business, or establishment in which employed (or employer)..... Clth. Mnfg.

9-BIRTHPLACE, (State or Country), Bavaria.,

PARENTS.

10-NAME OF FATHER, Reuben Skutch,

11-BIRTHPLACE OF FATHER (State or Country). Bavaria,

12-MAIDEN NAME OF MOTHER Zelina Houser,

13-BIRTHPLACE OF MOTHER (State or Country). Bavaria,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. F.F.Skutch,

(Address)..... Riviera Aprt.

15-

NOV 26 1917 ROBERT R. TRAUTMAN DEPUTY REGISTRAR

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 25th. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191 7, to Nov 28th 191 7.

that I saw h[illegible] alive on Nov 25th 191 7,

and that death occurred, on the date stated above, at 10 25 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration)..... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dealtro(e Nephritis)

(Duration) 15 yrs. mos. ds.

(Signed) Louis P. Hamburger M. D.

Nov. 26th, 191 7. (Address) 120 E. Lexington Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Balto. Hebrew, DATE OF BURIAL. Nov. 27th 191 7.

20-UNDERTAKER Harris Sondheim ADDRESS [illegible]

Cause of death must be properly classified. Each statement of fact is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10363

D10363

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Exeter ST.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon R. Wilkins

(Residence in Baltimore: No. 208 S. Exeter St.; 12 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 62 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Samuel Wilkins

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wilkins

(Address) 208 S. Exeter St.

15-

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 26 ....., 1917
(Month) (Day)* (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1915, to Nov. 26 1917, that I saw him alive on Nov. 26, 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

..... Chronic Nephritis &
..... Endocarditis .....
..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov. 27, 1917. (Address) 1802 E. Balto. St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Nov. 29, 1917

20-UNDERTAKER J. Fenton & Bro

ADDRESS 1107 E Balto St

CAUSE OF DEATH: In plain terms, so that it may be properly classified. Fill in all items, as far as they are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10364

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Kenwood Ave. 6 St.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry W^m Holmstrom Jr

(Residence in Baltimore: No. 425 N. Kenwood Ave St.; ..... yrs., 2 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 23, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Harry W^m Holmstrom

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary L. Bruce

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry W. Holmstrom

(Address) 425 N. Kenwood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 191 7, to Nov 26 191 7, that I saw h[illegible] alive on Nov 26 191 7, and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Convulsions

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Edward Gilcrest M. D.

11/26, 191 7 (Address) 413 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Nov 28, 191 7

20-UNDERTAKER Christian Miller — ADDRESS 2338 Jefferson

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D10365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D10365

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 917 n Paths Pk ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Ramsey.

(Residence in Baltimore: No. 917 n Path Park St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, Nov. 30, 1826
(Month) (Day) (Year)

7-AGE, 91 yrs. 1 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Weaver
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Lukemann

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Lukemann

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Ramsey

(Address) 917 n Path Park

15-

Filed Nov 27 1917 ROBERT R. KRAMER

....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ....
(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

.....
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs....mos....ds.

(Signed) J. Wm Paulson
(Coroner) ....M. D.

Nov 26, 191.7 (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death? ....
Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mechanicsburg Pa — DATE OF BURIAL, Nov 28, 1917

20-UNDERTAKER Christian Miller — ADDRESS 2334 Gilmore St

N. B.—Every item of information should be carefully stated. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10366

CERTIFICATE OF DEATH.

D10366

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Johnson

(Residence in Baltimore: No. 103 W. Franklin St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. August 19, 1917
(Month) (Day) (Year)

7-AGE. 3 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Johnson

11-BIRTHPLACE OF FATHER (State or Country), Texas

12-MAIDEN NAME OF MOTHER Gertrude Clark

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [signature]

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 7 1917, to Nov 26 1917, that I saw h er alive on November 26 1917, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Indigestion

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Colitis

(Duration) yrs. mos. 21 ds.

(Signed) J. M. Rivers M. D.

Nov. 26, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 20 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 103 W. Franklin St

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cemetery — DATE OF BURIAL, Nov. 27, 1917.

20-UNDERTAKER M. Doyle & Son — ADDRESS 15 E. Fayette St.

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10367

CERTIFICATE OF DEATH.

28 D10367

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Custer

(Residence in Baltimore: No. 412 Marion St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Nov. 14, 1849
(Month) (Day) (Year)

7-AGE, 68 yrs. 0 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 11 056

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Simon Custer

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Eliza Preston

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Custer Sr.

(Address) 412 Marion St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2[illegible] 191[illegible], to Nov. 28 191..., that I saw h[illegible] alive on Nov. 2[illegible] 191..., and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

I. Intercranial Hemorrhage
(Secondary)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

(Signed) Edward W. Sewall M. D.

Nov. 29, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 68 yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death? 412 Marion St.

Former or usual residence 412 Marion St.

19-PLACE OF BURIAL OR REMOVAL, Mt. Simon Va. DATE OF BURIAL, Nov. 28, 1917

20-UNDERTAKER Harry Hodges ADDRESS 1728 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D10368

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Page (#1 Twin)

(Residence in Baltimore: No. 1933 Lemon St. St.; 18 hrs. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) infant

6-DATE OF BIRTH, November (Month) 23 (Day), 1917 (Year)

7-AGE, ...yrs. ...mos. X ds.

If LESS than 1 day, 18 hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer) ~

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Walter Page

11-BIRTHPLACE OF FATHER (State or Country), ~~Edna~~ Balto. Md

12-MAIDEN NAME OF MOTHER Edna Hood

13-BIRTHPLACE OF MOTHER (State or Country), New Windsor, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter C. Page

(Address) 1933 Lemon St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov. 23 1917, to Nov. 24 1917, that I saw h[illegible] alive on Nov. 24 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

18 hrs

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) T. S. Jacobson M. D.

Nov 24 1917 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 11-26 1917.

20-UNDERTAKER Robert Brockett

ADDRESS Hollins

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119

D10369

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 South ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Johnson

(Residence in Baltimore: No. 646 South St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, August 18, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 4 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Mitchell

11-BIRTHPLACE OF FATHER (State or Country), District of Columbia

12-MAIDEN NAME OF MOTHER Marguerite Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marguerite Johnson

(Address) 646 South St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Nov 26 1917, that I saw him alive on Nov 26 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Toxaemia Uraemia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) T. E Daughtry M. D.

Nov 26, 191.., (Address) 1602 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Nov 26, 191..
20-UNDERTAKER	ADDRESS
James H. Dennis	313 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10370

CERTIFICATE OF DEATH.

91 D10370

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Myrtle ave ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Jackson

(Residence in Baltimore: No. 219 Myrtle ave St.; ....yrs., 4 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
male	negro	single

6-DATE OF BIRTH, Aug 14, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md. Baltimore

PARENTS.

10-NAME OF FATHER, Wm Percy Jackson

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md

12-MAIDEN NAME OF MOTHER Maranda Smith

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maranda Smith

(Address) 219 myrtle ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1917, to Nov 25 1917, that I saw h..... alive on ....191....., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (?)

.....

.....

..... (Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. McKay M. D.

....., 191... (Address) 739 George St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery

DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Presstman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-[illegible] M. & T.—2000 Bks.

D10371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 N. Bruce ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Blabe

(Residence in Baltimore: No. 1316 N. Bruce St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 15 (Day), 1885. (Year)

7-AGE, 32 yrs. 7 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Servant 070
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic

9-BIRTHPLACE, (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER, Richard Tongue

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Bertie Skriggs

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Tongue

(Address) 1308 N. Mount St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 24 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 20 1917., to Nov. 24 1917, that I saw her alive on November 23 1917, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles E. Clark M. D.

Nov 25, 1917. (Address) 1310 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov 27., 191.7.

20-UNDERTAKER James H. Dennis — ADDRESS 303 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10372

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10372

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1122 S Charles St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perry D Taylor

(Residence in Baltimore: No. 1122 S Charles St

St.: yrs. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH ..... April (Month) 25 (Day), 1917 (Year)

7-AGE ..... yrs. 7 mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or country) Preston Md Caroline Co

PARENTS

10-NAME OF FATHER Perry D Taylor

11-BIRTHPLACE OF FATHER (State or country) Preston Md

12-MAIDEN NAME OF MOTHER Gladys Reeder

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry D Taylor

(Address) Preston Md

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Filed NOV 27 1917, 191 ROBERT B. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov (Month) 26th (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 26th, 1917, to Nov 26th 1917, that I saw h- alive on Nov 26th, 1917, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Marasmus

History (Duration) yrs. 7 mos. ds

Contributory (SECONDARY) Immaturity

(Duration) yrs. mos. ds.

(Signed) Jno D Holt M. D.

Nov 26th, 191 (Address) 1037 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Preston, Md. DATE OF BURIAL: Nov 27, 1917

20-UNDERTAKER: Armstrong Danny Co ADDRESS: 713 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10373

CERTIFICATE OF DEATH.

x108 D10373

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac M. Thompson

(Residence in Baltimore: No. 5 days St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 5, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. 6 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Wm Thompson

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1917, to Nov. 26 1917, that I saw h[illegible] alive on Nov. 26 1917, and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

1. Primal pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Ford M. D.

Nov. 26, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Meadow Bluff W. Va

19-PLACE OF BURIAL OR REMOVAL, Meadow Bluff W Va DATE OF BURIAL, Nov. 27, 1917.

20-UNDERTAKER Albert E Fuller ADDRESS 221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT R. KRAMER
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D10374

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

28 D10374

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 574 St Mays st ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Rollins

(Residence in Baltimore: No. 574 St Mays st St.: 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Oct (Month) 30 (Day), 1896 (Year)

7-AGE, 21 yrs. 26 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Randolph Rollins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bertha Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Rollins

(Address) 574 St Mays st

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1917, to Nov 25 1917, that I saw her alive on Nov 24 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 7

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. Gordon M. D.

Nov 27, 1917. (Address) 11 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, Nov 29 1917.

20-UNDERTAKER, Jno H Holland | ADDRESS 631 D Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

Spec.—5-19-13—M. & T.—500 Blks.

D10375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D10375

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E 20th, ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Frazier

(Residence in Baltimore: No. 24 E 20th St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. Aug 12 (Month) (Day), 1917 (Year)

7-AGE, 5 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Moses Frazier

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER Fannie Scott

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Moses Frazier

(Address) 24 E 20 St

15-

Filed....., 191.....

Registrar.

NOV 27 1917 ROBERT H. KRAUTH Burial Permit

8

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1917, to Nov. 25th 1917, that I saw h— alive on Nov. 25 1917, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal catarrhal

..... (Duration) ...yrs. ...mos. 8 ...ds.

CONTRIBUTORY (Secondary) toxemia exhaustion

..... (Duration) ...yrs. ...mos. 5 ...ds.

(Signed) D. Grant Scott M. D.

Nov 27, 1917 (Address) 354 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel cmtry	Nov 28, 1917
20-UNDERTAKER Gro H Holland	ADDRESS 1631 E Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10376

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Hamilton Terrace ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James DuBué Ferguson.

(Residence in Baltimore: No. 826 Hamilton Terrace St.; Resident of Balto. for 40 yrs. yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, May (Month) 30 (Day), 1837 (Year)

7-AGE, 80 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Bankers.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), South Carolina.

PARENTS.

10-NAME OF FATHER, James Ferguson.

11-BIRTHPLACE OF FATHER (State or Country). South Carolina.

12-MAIDEN NAME OF MOTHER Abby Linn Barker.

13-BIRTHPLACE OF MOTHER (State or Country). South Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. William H. Brune

(Address) 826 Hamilton Terrace

15-

Filed....., 191.....

Registrar.

NOV 27 1917 ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1915, to Nov. 26th 1917, that I saw him alive on Nov. 25th 1917, and that death occurred, on the date stated above, at 10:36 A.m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia (Lobar-)
2. Contributory Arterio-Sclerosis
3. Had for two years - Pneumonia was Terminal

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) ....yrs....mos....ds.

(Signed) Wm F Lovelace M. D.

Nov 26th, 1917. (Address) E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Charleston, South Carolina. DATE OF BURIAL, Nov. 27th, 1917.

20-UNDERTAKER Henry H Jenkins Sons Co ADDRESS 711 E. Fayette & Orchard Sts.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Wr U 5334

5

Spec.—8-24-14—M. & T.—2000 Bks.

D10377. HEALTH DEPARTMENT—CITY OF BALTIMORE D10377.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 224 N. Fulton Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma T. Vidler

(Residence in Baltimore: No. 224 N. Fulton Ave. St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, April 27, 1843
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
62 yrs. 6 mos. 28 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER, Wm. Bendell

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER C. Nafe

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. T. Vidler

(Address) 224 N. Fulton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 191 6, to Nov 25 191 7, that I saw h.. alive on Nov 25 191 7, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 5 ds.

(Signed) John G. Hafer M. D.

Nov 26, 191.. (Address) 206 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Cemetery	Nov. 28, 1917.
20-UNDERTAKER	ADDRESS
Geo. J. Smith	1000 N. Fayett

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10378

D10378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 E Clement St.; W. WARD) REGISTERED NO. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillips Howard

(Residence in Baltimore: No. 411 E Clement St. St.; 40 yrs., — mos., — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1867 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): B & O 040

9-BIRTHPLACE, (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, Phillip Howard

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER Ann Brannon

13-BIRTHPLACE OF MOTHER (State or Country) Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. M. Shepard

(Address) 411 E Clement St

15-

Filed ....., 191.... C.T.O. Registrar.

NOV 27 1917 ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Nov 26 1917, that I saw h[illegible] alive on Nov 26 1917, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(Duration) ... yrs. ... mos. 2 ds.

(Signed) J. A. O'Donnell M. D.

Nov 27, 191... (Address) 1012 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Frederick Md | DATE OF BURIAL, Nov 28 1917

20-UNDERTAKER Wm Bradley Adam | ADDRESS 118 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D10379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10379

CERTIFICATE OF DEATH.

X 150

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jackson.

(Residence in Baltimore: No. 573 Green Willow St St.; ..... yrs., 1 mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 9 (Day), 1917 (Year)

7-AGE, ... yrs. 5 mos. 14 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), D. C.

PARENTS.

10-NAME OF FATHER, Alonzo Jackson

11-BIRTHPLACE OF FATHER (State or Country), D. C.

12-MAIDEN NAME OF MOTHER Mamie Brown.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C J Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.... Registrar.

5

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Nov 23 1917, that I saw h[illegible] alive on November 23 1917, and that death occurred, on the date stated above, at 7 10 p.m.

The CAUSE OF DEATH* was as follows:

Interna[illegible] Hydrocephalus

..... (Duration) ..... yrs. 05 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Daugherty M. D.

Nov. 23, 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 5 ds. In the State yrs. [illegible] mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 573 Green Willow St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Nov. 27, 191.7

20-UNDERTAKER Samuel Cowan Co - ADDRESS 916

Spec.—8-24-14—M. & T.—2000 Bks.

D10380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10380

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 W. Fremont Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Liberto

(Residence in Baltimore: No. 1139 W. Fremont Ave St.; ....yrs., 1 mos. 29 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1917 (Year)

7-AGE, ...yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Casimo Liberto

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosina Aquila.

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Casimo Liberto

(Address) 1139 W. Fremont Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18. 1917, to Nov. 26, 1917, that I saw h... alive on Nov. 26, 1917, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

.....

Illus-entitis

.....

.....

..... (Duration) ....yrs. ....mos. 9 ....ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Eugene L. Passagno M. D.

Nov. 27, 191... (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Nov 27, 191...

20-UNDERTAKER	ADDRESS
Daniel Taylor	Balto

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D1038F

D1038F

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 N. Mount ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Logan

(Residence in Baltimore: No. 1628 N. Mount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, age 43 (Month) (Day) 1 (Year)

7-AGE, age 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stitcher Singing
(b) General nature of industry, business, or establishment in which employed (or employer). Linen Co

9-BIRTHPLACE, (State or Country), Danville Va.

PARENTS.

10-NAME OF FATHER, Henry Taylor

11-BIRTHPLACE OF FATHER (State or Country), Danville Va

12-MAIDEN NAME OF MOTHER Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Danville Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Shibley

(Address) 1628 N. Mount St.

15-

Filed ....., 191.....

ROBERT B. KRAUTH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Nov 25 1917, that I saw h[er] alive on Nov 25 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11-26, 1917. (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Nov. 27, 1917

20-UNDERTAKER Felix B. Pyle

ADDRESS 1026 Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10382
1PLACE OF DEATH

CERTIFICATE OF DEATH

6 D10382
REGISTERED No. C

CITY OF BALTIMORE (No. 1803 Jefferson pl. St. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Martini

(Residence in Baltimore: No. 1803 Jefferson St.: 5 yrs. 7 mos. 11 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Apr 15th (Month) (Day), 1912 (Year)

7-AGE: 5 yrs. 7 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): City

PARENTS

10-NAME OF FATHER: August Martini
11-BIRTHPLACE OF FATHER (State or country): Md
12-MAIDEN NAME OF MOTHER: Leliah Haynes
13-BIRTHPLACE OF MOTHER (State or country): N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) August Martini
(Address) 1803 Jefferson

15
Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 26 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1917, to Nov. 26 1917.
that I saw her alive on Nov. 26, 1917.
and that death occurred, on the date stated above, at 6.55 P m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 3 ds
Contributory (SECONDARY): measles
(Duration) yrs. mos. 6 ds.

(Signed), Michael A. Shamel M. D.
Nov 26. 1917. (Address) 1634 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the ds. State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel | DATE OF BURIAL: Nov 27. 1917

20-UNDERTAKER: Philip Herwig | ADDRESS 2016 Orleans St

5

D10383

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10383

CERTIFICATE OF DEATH

120

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2843 Greenmount Av ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kusgmaul

(Residence in Baltimore: No. 2843 Greenmount av St.; 41 yrs. ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: January (Month) 31, (Day) 1844 (Year)

7-AGE: 73 yrs. 10 mos. 27 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Butcher (retired)
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Koenig Kusgmaul

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Sophie Klein

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William A. Kusgmaul

(Address) 2843 Greenmount Ave

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 27 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1917, to, November 27, 1917, that I saw him alive on November 22, 1917, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
Hepatic cirrhosis

(Duration) — yrs 11 mos. — ds.

Contributory (SECONDARY) .....

(Duration) ... yrs ... mos. ... ds.

(Signed) C. D. Steenken M. D.

November 27, 1917. [Address] 4005 Greenmount Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount

DATE OF BURIAL: Nov 30, 1917

20-UNDERTAKER: Lowe Cook

ADDRESS: 502 E Hoffman

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10384

CERTIFICATE OF DEATH.

79 ✓ D10384

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 Gorsuch Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Young

(Residence in Baltimore: No. 1639 Gorsuch Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Wife

6-DATE OF BIRTH. October (Month) 30 (Day), 1891 (Year)

7-AGE. 26 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 069

221

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Fred Young

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Christine Steinbach

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Young

(Address) 1639 Gorsuch Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 25 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1917, to Nov 25 1917, that I saw her alive on Nov 25 1917, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Chas A Schaefer M. D.

Nov 26, 191.. (Address) 2013 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Co Lm	Nov 28, 191..
20-UNDERTAKER Wm Cook	ADDRESS 502 S Mott Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10385

CERTIFICATE OF DEATH.

D10385

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 S. Mount ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Sherlay

(Residence in Baltimore: No. 335 S. Mount St.; ....yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED~~ WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, July 21, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Painter
(b) General nature of industry, business, or establishment in which employed (or employer): 050

328

9-BIRTHPLACE, (State or Country), Hardyston N.J.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Sherlay M.D.

(Address) 701 N. Carrollton Ave.

15-

Filed....., 191....

Registrar.

Mar 583 9/5

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 26th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9th 1917, to Nov 26th 1917, that I saw h.. alive on Nov. 26th 1917, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Terminal

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Thomas Sherlay M. D.

Nov 26, 191.. (Address) 701 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 21 ds. In the State ....yrs. ....mos. 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York.

19-PLACE OF BURIAL OR REMOVAL, Dug Lanton N.Y.

DATE OF BURIAL, Nov 27, 191..

20-UNDERTAKER Joseph T. Cook

ADDRESS 1003 W. Balto St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10386

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... St.; 19 Ward)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Lee Lavage

(Residence in Baltimore: No. 1537 W. Fayette St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1855 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) ..... U. S. N. Y81

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, William H. Lavage

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Maria R. Redinger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Hosp. Records

(Address) ..... University Hosp.

15-

Filed ....., 191.....

Registrar.

NOV 27 1917 ROBERT B. KRAUTER Burial Permit Clerk

5

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 26 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Nov 26 1917, that I saw h[illegible] alive on Nov 26 1917, and that death occurred, on the date stated above, at 12 mid.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

Operation (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... M. D.

11/26, 191.7 (Address) ..... University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1534 W. Fayette St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. — DATE OF BURIAL, Nov 29, 191.7

20-UNDERTAKER Joseph D. Cook — ADDRESS 1003 Madison St

N. B.—Every item of information should be carefully applied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10387

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D10387.

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1820 N. Monroe St.: 15 WARD)

2 FULL NAME Sallie L. Nichols

(Residence in Baltimore: No. 1820 N. Monroe St.: 43 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Dec 26, 1873 (Month) (Day) (Year)

7 AGE: 46 yrs. 11 mos. ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm C Stubbs

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary E. VanSant

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nellie Gregory

(Address) 1820 N. Monroe

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 26, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1917, to Nov 26 1917, that I saw h-r alive on Nov 25, 1917, and that death occurred, on the date stated above, at 8:30 a m. The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) ..... yrs. 7 mos. ..... ds

Contributory (SECONDARY) Sept. Toxic

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) R M Cranmer M. D.

11/26, 1917 (Address) 901 N. Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Nov 28, 1917

20 UNDERTAKER: Chas E. Franck — ADDRESS: 807 Madison Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10388

CERTIFICATE OF DEATH

D10388

Registered No. C 64

1 PLACE OF DEATH

City of Baltimore (No. 3822 Garrison Av St. 15 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Lee Bledsoe

(Residence in Baltimore: No. 3822 Garrison Av St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) 6 (Day), 1874 (Year)

7 AGE: 43 yrs. 6 mos. 20 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: State agent
(b) General nature of industry, business, or establishment in which employed (or employer): Brewing Co 086

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Robert Bledsoe

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Margaret Walker

13 BIRTHPLACE OF MOTHER (State or country): Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Beulah Bledsoe

(Address) 3822 Garrison Av

15

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 25 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1917, to Nov 25 1917, that I saw him alive on Nov 25 1917, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

..... (Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY): Cardiac Asthenia

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed), A W Bridenbaugh M. D.

....., 191.... (Address) 3743 Park Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Nov 28, 1917

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 807 Madison Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10389

CERTIFICATE OF DEATH.

× 64 ✓ D10389

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Boston & Leakin St 2 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Bozman

(Residence in Baltimore: No. Boston & Leakin sts. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 9th 1897, 1 (Month) (Day) (Year)

7-AGE, 20 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Sailor (b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Monie Md.

PARENTS.

10-NAME OF FATHER, Massey Bozman

11-BIRTHPLACE OF FATHER (State or Country). Monie Md.

12-MAIDEN NAME OF MOTHER Elizabeth Bozman

13-BIRTHPLACE OF MOTHER (State or Country), Monie Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Hale

(Address) 115 E. West St.

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Thomas Sydnor Pond Jr M. D. (Coroner.)

Nov 27, 1917 (Address) 1610 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Monie Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Deals Island Md	Nov 27, 1917
20-UNDERTAKER	**ADDRESS**
E & B Hale	115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

D10390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10390

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2655 Frederick ST.; 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia H. Adams

(Residence in Baltimore: No. 2655 Frederick St.; 2 yrs., 3 mos. 15 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 22 (Month), 1915 (Year)

7-AGE, 2 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Lawrence Adams

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Louise Gieselman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Gieselman

(Address) 2655 Frederick

15-

Filed ....., 191....

Registrar.

NOV 27 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26 (Month) (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov 6 191 7, to Nov 26 191 7, that I saw her alive on Nov 26 191 7, and that death occurred, on the date stated above, at 2 0. m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) ....yrs. ....mos. 18 ds.

CONTRIBUTORY (Secondary) Ex Laneston

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. H. Lucas M. D.

11/26, 191... (Address) Lanston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL, Nov 28, 1917.

20-UNDERTAKER Geo E Schnabel & Bro ADDRESS 2101 Eutaw ave

D10391

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 V D10391
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 955 Gorsuch ave St.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Martha W. Sinnott

(Residence in Baltimore: No. 955 Gorsuch ave St.: 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: about (Month) (Day), 1849 (Year)

7 AGE: about 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. B. Sluttler

(Address) 955 Gorsuch ave

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 26th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1916, to Nov. 16 1917.

that I saw h-- alive on Nov. 16, 1917.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

000

(Duration) 1 yrs. 6 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) 6 J Buchanan Jr M. D.

Nov 26, 1917 (Address) 632 Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Johns Westminster — DATE OF BURIAL: Nov 28th, 1917

20 UNDERTAKER: W. W. Gawthrop — ADDRESS: 1624 McHenry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C D10392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Bolton ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Robert McCoy

(Residence in Baltimore: No. 1723 Bolton St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: April 22, 1838 (Month) (Day) (Year)

7-AGE: 79 yrs. 7 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Florida

PARENTS.

10-NAME OF FATHER: Robert F Wilson

11-BIRTHPLACE OF FATHER (State or Country): N.C.

12-MAIDEN NAME OF MOTHER: Harriet Epum

13-BIRTHPLACE OF MOTHER (State or Country): N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paddy McCoy Keirle

(Address) 1417 W Lexington St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: November 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1917, to Nov 25 1917, that I saw h[illegible] alive on Nov. 25 1917, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gall Stones & Chronic Myocarditis

(Duration) 1 yrs. 2 mos. ds.

(Signed) Edward McAleer M. D.

Nov 27, 1917 (Address) 1609 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL, Nov 28, 1917

20-UNDERTAKER John J Mitchell

ADDRESS 1201 W Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 27 1917

REGISTRAR

D10393

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 D10393

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3411 Guilford Terrace St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha L. Hendrickson

(Residence in Baltimore: No. 3411 Guilford Terrace St.; 56 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Aug. 6, 1846 (Month) (Day) (Year)

7-AGE: 71 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10-NAME OF FATHER: Richard E. Miller

11-BIRTHPLACE OF FATHER (State or country): Ellicott City

12-MAIDEN NAME OF MOTHER: Elizabeth E. Butler

13-BIRTHPLACE OF MOTHER (State or country): Montgomery Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ethel H. Dasey

(Address) 3411 Guilford Terrace

15

Filed NOV 27 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 26th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th 1917, to Nov 26th 1917, that I saw h[er] alive on Nov 26th, 1917, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Organic heart trouble of long standing Chronic dilatation with chronic complications (Duration) one yrs. mos. ds

Contributory (SECONDARY) Prominent Contributing factor (Duration) 15 yrs. mos. ds.

(Signed) Geo H Cowman M. D.

Nov 27th, 1917 (Address) 2117 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem[etery]

DATE OF BURIAL: 11/28 1917

20-UNDERTAKER: Henry W. Maus & Son

ADDRESS: 805 N. Gay St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10397 D10394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 St. Paul Street, St.; 12 Ward) REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara A. Delcher

(Residence in Baltimore: No. 2829 St. Paul St. St.; 78 yrs. 10 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January 21, 1839
(Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
78 yrs. 10 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frank C. Lowry

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Matilda Sapp

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irving B. Delcher

(Address) 2928 N. Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12, 191 7, to Nov. 25, 191 7, that I saw h alive on " 191 7, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 6 yrs. mos. ds.

(Signed) George H. Hartman M. D.

Nov. , 191 (Address) 1211 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Nov. 28, 1917

20-UNDERTAKER	ADDRESS
Henry W. Maus & Son	1054 Gilmor St.

N. B.—Every item or information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10395

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 D10395

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2929 Belmont Ave. ST.: E 2 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Irene O. Selby.

(Residence in Baltimore: No. 2929 Belmont Ave. St.: 48 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married.

6 DATE OF BIRTH: April 14th. (Month) (Day), 1856. (Year)

7 AGE: 61 yrs. 7 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 00 00

9 BIRTHPLACE (State or country): Ohio.

PARENTS

10 NAME OF FATHER: Albert Watts.

11 BIRTHPLACE OF FATHER (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: ------ Norris.

13 BIRTHPLACE OF MOTHER (State or country): Do not know.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lawrence A. Selby. (husband)
(Address): 2929 Belmont Ave.

15 Filed NOV 27 1917, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November, 25th. (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31st, 1917, to Nov, 25th. 1917, that I saw her alive on Nov, 25th. 1917, and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart
and Chronic Nephritis.
8
(Duration) yrs. mos. ds

Contributory (SECONDARY) Myocarditis.
(Duration) yrs. mos. ds.

(Signed) Otto M. Eberhart M. D.
Nov. 26th. 1917. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: 11 28 1917

20 UNDERTAKER: J. Fenn McCarthy ADDRESS: 100 E. Fort

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

D10396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10396

CERTIFICATE OF DEATH.

28 ✓

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Myrtle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Dyer

(Residence in Baltimore: No. 919 Myrtle Ave St.; 50 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 645

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Dyer

(Address) 919 Myrtle Ave

15-

Filed ....., 191.....

Registrar.

NOV 27 1917 ROBERT B. ERADDEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1916, to Nov 25 1917, that I saw h[illegible] alive on Nov 25 1917, and that death occurred, on the date stated above, at 1.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. S. Fulton M. D.

Nov 26, 1917 (Address) 220 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	11-28, 1917
20-UNDERTAKER John H. Soadin	ADDRESS 1.42 W. Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10397.

CERTIFICATE OF DEATH.

D10397.

120

1-PLACE OF DEATH 613 N Decker Ave

CITY OF BALTIMORE: (No. 7 ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Killian

(Residence in Baltimore: No. 613 N Decker Ave St.; 20 yrs.. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) 1 (Day), 1 (Year)

7-AGE. 35 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 04

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Frank Killian

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Killian

(Address) 613 N Decker Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day), 1917 (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 18 1917, to Nov 25 1917, that I saw h[e] alive on Nov 25 1917, and that death occurred, on the date stated above, at 1145P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 26, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Nov 28, 1917

20-UNDERTAKER Frank Leach Son

ADDRESS 1916 Eastlake

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10398

CERTIFICATE OF DEATH.

105 D10398

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N Duncan ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Sluka

(Residence in Baltimore: No. 405 N Duncan St. 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Not Known ....., 1..... (Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

243

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Mathy Sluka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sluka

(Address) 405 N Duncan

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26 1917, to Nov 26 1917, that I saw h[illegible] alive on Nov 26 191..., and that death occurred, on the date stated above, at 8.10 a m.

The CAUSE OF DEATH* was as follows:

..... Acute Enteritis .....

..... (Duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary) Chron. Intoxication

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Elijah J. Powell M. D.

Nov 27th, 1917. (Address) 416 N Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Oak Hill

DATE OF BURIAL, Nov 28, 1917

20-UNDERTAKER Frank Brack & Son

ADDRESS 1906 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10399

CERTIFICATE OF DEATH.

175 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Breiden & Selleman Sanatorium WARD) 16

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. K. Wiley

(Residence in Baltimore: No. 724 N. Carey St. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Nov 7, (Month) (Day) 1843 (Year)

7-AGE, 74 yrs. 0 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella B. Wiley

(Address) 724 N. Carey

15- NOV 27 1917

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock due to fracture of femur

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Thos. Morrison M. D. (Coroner)

Nov 27 1917 (Address) 3632 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 18 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Fort Mc Hood Ala

Former or usual residence 724 N. Carey St.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Nov 28, 1917
20-UNDERTAKER	ADDRESS
Mr & Mrs John W. Lenfest	801 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10400

135

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Strawberry

(Residence in Baltimore: No. 109 Lodendale St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Married

6-DATE OF BIRTH, Not Known ....., 1..... (Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER Mary Denby

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Strawberry

(Address) 109 Lodendale St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 191 7, to Nov 25 191 7, that I saw h alive on Nov 25 191 7, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Acute Nephritis

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Edward J. Quick M. D.

Nov 26, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 7 ds. In the State yrs. 27 mos. ds.

Where was disease contracted, if not at place of death? 109 Lodendale St.

Former or usual residence 109 Lodendale St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 27, 1917.

20-UNDERTAKER L. R. Brown & Son

ADDRESS 501 W Monty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D1040?

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D1040?

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. Hill St.: 27 WARD) REGISTERED NO. C

2-FULL NAME John W. Hughes

(Residence in Baltimore: No. 211 W Hill St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Single

6-DATE OF BIRTH. ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, James Hughes

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Edward Hughes

(Address). 218 Warren St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 1917, to Nov 27 1917, that I saw h[illegible] alive on Nov 26 1917, and that death occurred, on the date stated above, at 7.25 a. m.

The CAUSE OF DEATH* was as follows: (1) Pneumonia (2) Coma

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) ..... yrs. 1 mos. 7 ds.

(Signed) C. H. Flinn M. D.

Nov 27, 1917 (Address) 712 S. Kenwood Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Nov 29, 191 7

20-UNDERTAKER A. L. Brown's Son | ADDRESS [illegible] County

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10402 HEALTH DEPARTMENT—CITY OF BALTIMORE D10402

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 E. Pleasant ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Theodore Montell

(Residence in Baltimore: No. 107 E. Pleasant St.; ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1854 (Year)

7-AGE, 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bottle Cork
(b) General nature of industry, business, or establishment in which employed (or employer): Cork

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Montell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Gough

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Montell

(Address) 107 E. Pleasant St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 27 1917, that I saw h in alive on Nov 26 1917, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia

(Duration) ..... yrs. ..... mos. 4th 1 week ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 27, 1917 (Address) 607 N Chester St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Nov 29, 1917
20-UNDERTAKER John A. Bishop	ADDRESS 110 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT R. KRUTER
Registrar of Vital Records

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10403
1PLACE OF DEATH

CERTIFICATE OF DEATH

43 D10403
REGISTERED No. C

CITY OF BALTIMORE (No. 2325 Mondawmin Ave St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Maggie M. Stevens

(Residence in Baltimore: No. 2325 Mondawmin Ave St. 32 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: August 5th, 1856 (Month) (Day) (Year)

7-AGE: 61 yrs. 3 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Wm. H. Councell
11-BIRTHPLACE OF FATHER (State or country): Maryland
12-MAIDEN NAME OF MOTHER: Margaret J. Parr
13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Stevens
(Address) 2325 Mondawmin Ave.

15-
Filed ....., 191.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 27th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1917, to Nov 27th 1917, that I saw h.. alive on Nov 26th, 1917, and that death occurred, on the date stated above, at 1-45 Am.
The CAUSE OF DEATH* was as follows:

Carcinoma
Primary in left breast

(Duration) 1 yrs. 2 mos. — ds

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) Eugene Douglass M. D.
Nov. 27th, 1917 (Address) 830 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov. 29, 1917.

20-UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10401

1 PLACE OF DEATH

15 ✓ D10401

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1320 Morling Ave St. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard D Estell Martin

(Residence in Baltimore: No. 1320 Morling Ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colrle	Single

6-DATE OF BIRTH Nov (Month) 11 (Day), 1917 (Year)

7-AGE ..... yrs. ..... mos. 16 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) — 800

9-BIRTHPLACE (State or country) Balto Md.

PARENTS

10-NAME OF FATHER John W. Martin

11-BIRTHPLACE OF FATHER (State or country) Mount Royal Va

12-MAIDEN NAME OF MOTHER Francis M. Newman

13-BIRTHPLACE OF MOTHER (State or country) Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. M. Newman

(Address) 1320 Morling Ave.

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/11/17, 191 . to. 11/27 1917.

that I saw him alive on 11/27 .191 7.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Duration

(Duration) ..... yrs. ..... mos. 11 ds

Contributory (SECONDARY) Eclampsia - mothers

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo W Estell M. D.

11/28, 191 7. (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Carroll Chapel | DATE OF BURIAL Nov 29, 1917

UNDERTAKER H S Marshall | ADDRESS 3539 Fall Rd

NOV 28 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D10405 HEALTH DEPARTMENT—CITY OF BALTIMORE D10405

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1365 N. Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Johnson

(Residence in Baltimore: No. 1365 N. Carey St.; 32 yrs., mos. ds.) in City.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	C	Single

6-DATE OF BIRTH, April 1 (Month) (Day), 1878 (Year)

7-AGE, 39 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver. 023
(b) General nature of industry, business, or establishment in which employed (or employer): Horse & Wagon

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Lewis Johnson

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md

12-MAIDEN NAME OF MOTHER Elizabeth Gray

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Snapp wife

(Address) 1365 N. Carey St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1917, to Nov 27 1917, that I saw h[illegible] alive on November 26 1917, and that death occurred, on the date stated above, at 8.25 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

H. Hypertrophy ?

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Thos. H. Wrightson M. D.

Nov 27, 1917. (Address) 1209 Hesselman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Nov. 29, 1917.

20-UNDERTAKER Jno H. Holland ADDRESS 631 Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10406

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D10406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Kuper Place ST.; 19 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Neary

(Residence in Baltimore: No. 1306 Kuper Place St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Aug (Month) 24 (Day), 1860. (Year)

7-AGE, 57 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Virtue

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Eliza Rogan

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barnes

(Address) 1306 Kuper Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1916, to Nov 26 1917, that I saw her alive on Nov 26 1917, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage causing right Hemiplegia and Aphasia

(Duration) 1 yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) Recurring Cerebral Hemmorrhage

(Duration) 1 yrs. 1 mos. 13 ds.

(Signed) Henry C. Ohle M. D.

Nov 26, 1917. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Nov 29, 1917.

20-UNDERTAKER John J. Fields — ADDRESS 1200 W Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INDELIBLE PENCIL.

NOV 28 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10407

D10407

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 847 Rembart St., 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel D Gray

(Residence in Baltimore: No. 847 Rembart St.: — yrs., 2 mos. 7 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Feb 20, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, L D Gray

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Martha Vincent

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L D Gray

(Address) 847 Rembart

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Nov 27 1917, that I saw h alive on Nov 25 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Bronchial pneumonia

(Duration)..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) John F. Schwenker M. D.

Nov 27, 191.. (Address) 1120 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel

DATE OF BURIAL. Nov 29, 191.

20-UNDERTAKER John J Fields

ADDRESS 1200 W Lanvale

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10408

CERTIFICATE OF DEATH.

108 ✓ D10408

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Bank. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Niederwemmer

(Residence in Baltimore: No. 1420 Bank St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 9 (Day) 1912 (Year)

7-AGE, 5 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER August Niederwemmer

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Katherine Nash

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Nash

(Address) 1420 Bank St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1917, to Nov 27 1917, that I saw h-- alive on Nov 27 1917, and that death occurred, on the date stated above, at 11.5 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro duodenitis

Acute Appendicitis

Acute Peritonitis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. 1 ds.

(Signed) E. V. Cordell M. D.

11/28, 1917. (Address) 74 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Nov 29., 1917.

20-UNDERTAKER Wendell Deppel

ADDRESS 37 S. Arch St

D10409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10409

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital, St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoinette Hallman

(Residence in Baltimore: No. 2711 Belair Road; St.; 5 yrs., 4 mos. 29 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Sgl

6-DATE OF BIRTH. June 28, 1912
(Month) (Day) (Year)

7-AGE. 5 yrs. 4 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. school 000
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Louis Hallman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Barbara Schuler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Hallman

(Address) 2711 Belair av

15-

NOV 28 1917 HOWARD R. KRAUSE Burial P.

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 26, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Influenza Pleurisy
Duration 2 days

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
Nov 28, 191.. (Address) 7 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. Nov 29, 191.

20-UNDERTAKER Henry Horock & Son

ADDRESS 1301 E Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N Paul St. WARD) 79

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Mullen

(Residence in Baltimore: No. 11 N Paul St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 7, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer) 5000

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Kilpatrick

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Janet Kunn

13-BIRTHPLACE OF MOTHER (State or Country), Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma C Piper

(Address) 11 N. Paul St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12th 1917, to Nov 24 1917, that I saw h e alive on Nov 24 1917, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) Elmer B Emerson M. D.

11/26, 191.7 (Address) 417 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov 28 191.

20-UNDERTAKER Robt J Lunder

ADDRESS 1822 Bway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10411 HEALTH DEPARTMENT—CITY OF BALTIMORE D10411

CERTIFICATE OF DEATH.

91v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N Eden ST. 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J Clarke

(Residence in Baltimore: No. 1018 N. Eden St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 8, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Lawrence Clarke

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary Ann Miles

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Clarke

(Address) 1018 N Eden St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 18 191.., to Mar 26 1917, that I saw h.. alive on Mar 26 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....Pneumonia.....

.....

.....

.....Hours..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

.....1 week..... (Duration)...0...yrs.....mos.....ds.

(Signed).....C H Brune.....M. D.

Mar 28, 191... (Address) 1132 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Mar 29, 191..

20-UNDERTAKER Rapp & Sumner — ADDRESS 1427 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10412

CERTIFICATE OF DEATH.

D10412

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Moreland ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas B. Talbott

(Residence in Baltimore: No. 1736 Moreland ave St.; 47 yrs., 3 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August (Month) 9 (Day), 1870 (Year)

7-AGE, 47 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer 063
(b) General nature of industry, business, or establishment in which employed (or employer): a Hoen + Co

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Nicholas B Talbott Jr

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Phillips

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stella O Talbott

(Address) 1736 Moreland ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 27th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1917, to Nov. 27th 1917, that I saw him alive on Nov. 27th 1917, and that death occurred, on the date stated above, at 2.50 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Clinical

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov. 28, 1917. (Address) 5 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Nov. 30th, 1917.

20-UNDERTAKER George Schilling + Sons

ADDRESS 1126 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10413

CERTIFICATE OF DEATH.

120

D10413

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1016 Fawn ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rhesia De Angelis

(Residence in Baltimore: No. 1016 Fawn St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, December (Month) 15 (Day) 1864 (Year)

7-AGE, 52 — 53 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of Industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Anthony Boob

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Angela Bove

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Demalis

(Address) 1016 Fawn St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Nov 26 1917, that I saw h[illegible] alive on Nov 27 1917, and that death occurred, on the date stated above, at 11 6 m.

The CAUSE OF DEATH* was as follows:

Acute Bright's

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) L Wiseman M. D.

Nov 7, 1917. (Address) 16 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent	Nov 29, 1917
20-UNDERTAKER	ADDRESS
Wendell Wyffel & Son	378 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

D10414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 | D10414

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Fayette St.; WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Teresa Romaguera

(Residence in Baltimore: No. 511 Gaylor St.; yrs., mos. 6 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE, OCCUPATION and CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) Nov (Day) 24, (Year) 1911

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 6 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Antonio Romaguera

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Paulina Massari

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonio Romaguera

(Address) 1517 Gaylor St.

15- .....

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Nov (Day) 24, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1917, to Nov 24 1917, that I saw h at alive on Nov 24 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia Lobar (Primary)

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Nov 25, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent

DATE OF BURIAL, Nov 27, 1917

20-UNDERTAKER Mudell Tippel Asso

ADDRESS 1330 S. Paca St

D10415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10415

CERTIFICATE OF DEATH.

169

REGISTERED No. C.....

1.PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 10 St.; WARD)

2.FULL NAME Peter Duffy

(Residence in Baltimore: No. 609 E. Biddle St.; yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, May 1 (Month), 1866 (Day) (Year)

7-AGE. 51 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): Own 086

650

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Duffy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Moran

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Alice Duffy

(Address) 609 E Biddle

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:-

Stomach Hemorrhage

Duration (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) W. J. Peter M. D.
(Coroner.)

Nov 26, 191.. (Address) 16 W. Penn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Nov 29, 1917.

20-UNDERTAKER P. C. Weadefeld ADDRESS 914 Drummond Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D10416

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 R. chardson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Waszkiewicz

(Residence in Baltimore: No. 1442 Richardson St.; 1 yrs., mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov (Month) 2 (Day) 1916 (Year)

7-AGE, 1 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

000 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michal Waszkiewicz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ang Stasewicz

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Waszkiewicz

(Address) 1442 Richardson

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11-27- (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-15- 1917, to 11-27- 1917, that I saw h[illegible] alive on [illegible] 11-26- 1917, and that death occurred, on the date stated above, at 1.P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Thrush

(Duration) yrs. 3 mos. ds.

(Signed) [illegible] M. D.

11-27-, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, 11-28-, 191.7

20-UNDERTAKER William Fralsowsky

ADDRESS 818 Easter Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10417

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 ✓ D10417

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 416 S. Payson ST. 20 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John I. German

(Residence in Baltimore: No. 416 S. Payson St.; 72 yrs. ✓ mos. ✓ ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: 6 (Month) 7 (Day), 1845 (Year)

7-AGE: 72 yrs. 4 mos. ✓ ds. If LESS than 1 day ..... hrs. or ..... mts.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Brick-mason
(b) General nature of industry, business, or establishment in which employed (or employer): 012

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: John German

11-BIRTHPLACE OF FATHER (State or country): Balto. Co. Md.

12-MAIDEN NAME OF MOTHER: Elizabeth Strebeck

13-BIRTHPLACE OF MOTHER (State or country): Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. I. German

(Address) 3939 Lounder Ave.

15-

Filed ..... , 191 .....

REGISTRAR

NOV 28 1917 ROBERT N. KRAUTER Burial Estate Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 11 (Month) 26 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1917, to Nov 26 1917, that I saw him alive on Nov 26, 1917, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY): Bright Disease - Uremia

(Duration) X yrs. X mos. 10 ds.

(Signed) I. P. Wilson M. D.

1127 , 191 7 (Address) 1939 Wilkens Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem

DATE OF BURIAL: 11-29 1917

20-UNDERTAKER: Robert Brooks & Son

ADDRESS: 17 S. Calhoun St

Spec.—8-24-14—M. & T.—2000 Bks.

D10418

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D10418

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 849 Woodward St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Stephenson

(Residence in Baltimore: No. 849 Woodward St.: 34 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (*Write* the word.) widow

6-DATE OF BIRTH, ... June (Month) 22 (Day), 1845 (Year)

7-AGE, 72 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Howard Co md

PARENTS.

10-NAME OF FATHER, Jerome L. Stark

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Mary A. Whitehead

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Stephenson

(Address) 849 Woodward St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, — November (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Nov 27 1917, that I saw h[illegible] alive on Nov 27 1917, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(Non Intervention)

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) yrs. 7 mos. ds.

(Signed) [illegible] M. D.

Nov 28, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, Nov 30, 191.7

20-UNDERTAKER Sol Foerderer Inc — ADDRESS 217 S Bro

1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be readily understood. Correct statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

6 D10419
5 6

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D10419

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hohnamann Hosp ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Fay (Fay)

(Residence in Baltimore: No. 112 S. Williams St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October, 15, 1855
(Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer on a Barge
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, August Fay

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Sophia Graber

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Self

(Address) 112 S. Williams St

15-

Filed....., 191.....
Registrar.

NOV 28 1917
ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Broken Neck & Concussion of Brain by a Fall from a Barge
(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Lost his balance & Fell
(Duration) yrs. mos. ds.

(Signed) H. McWilliams M. D.
(Coroner)
....., 191.. (Address) 19 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. | DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER E & B Hahn | ADDRESS 112 E West St

John Jackson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10420 **CERTIFICATE OF DEATH.** 150 D10420

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1912 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Jackson

(Residence in Baltimore: No. 1912 McCulloh St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 26 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Nov 28

12-MAIDEN NAME OF MOTHER Rosa Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Unknown

(Address) 1912 McCulloh

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Pneumonia
2. Bronchial
3. Duration 1 day

CONTRIBUTORY (Secondary) Carcinoma (Duration) yrs. mos. ds.

(Signed) H. McCollum M. D. (Coroner.)

....., 191.. (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

JOHNS HOPKINS HOSPITAL NOV 28 1917 LIBRARY

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D10421 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 109 D10421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 ~~20~~ E. Barney ST.; 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary H. Morris

(Residence in Baltimore: No. 7 E. Barney St.; 50 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1856 (Year)

7-AGE, 59 yrs. 9 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jacob McAbee

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Christina Butler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmore A. Morris

(Address) 7 E. Barney St.

15-

NOV 28 1917 BERNEY A. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Nov 27 1917, that I saw her alive on Nov 27 1917, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Strangulated umbilical hernia

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Coma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Neale Stiffler M. D.

11/28, 1917. (Address) 1319 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem. DATE OF BURIAL, Nov 29, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light St

Spec.—8-24-14—M__T.—2000 Bks.

D10422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Wilcox St.; 10 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda M. Freshline

(Residence in Baltimore: No. 1016 Wilcox St.; 33 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. June 25, 1866 (Month) (Day) (Year)

7-AGE. 51 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 137

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Lindsay Baird

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Annie MacLucas

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Freshline

(Address) 1016 Wilcox St.

15-

Filed....., 191.....

ROBERT R. KRAUTER
CAPITAL POTENTIAL

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Nov 27 1917, that I saw her alive on Nov 26 1917, and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Carcinoma 7

Asthenia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Tuberculosis

(Duration) yrs. 3 mos. ds.

(Signed) James M Burden M. D.

Nov 28, 1917 (Address) 700 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER Elmer W. Conklin — ADDRESS 424 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10423

CERTIFICATE OF DEATH.

151 D10423

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3209 Barclay ST. 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Rogers

(Residence in Baltimore: No. 3209 Barclay St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	Cl	Single

6-DATE OF BIRTH, ..11.. (Month) 26 (Day), 1917 (Year).

7-AGE, ...yrs....mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Roach

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Bertha Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Roach

(Address) 3209 Barclay St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..11.. (Month) 28 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Nov 28 1917, that I saw her alive on Nov 28 1917, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Premature birth (cause unknown) Period of Gestation

(Duration) ...yrs. 7 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) R Garnet Chenault M. D.

Nov 28, 1917. (Address) 1534 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Druid Cemetery DATE OF BURIAL, Nov 30, 1917.

20-UNDERTAKER Chas G Bailey ADDRESS Jefferson at

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 28 1917 ROBERT N. KRANTZ

Spec.—8-24-14—M. & T.—2000 Blks.

D10421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10421

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Hollins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Weegard

(Residence in Baltimore: No. 1000 Hollins St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 25, 1850 (Month) (Day) (Year)

7-AGE, 67 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Bluss

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Florence Rest

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. E. Weedemd

(Address) Washington DC

15-

NOV 28 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11.30 AM Nov. 27 1917, to 4.30 PM. Nov 27 1917, that I saw h- alive on Nov 27 1917, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Natural Regurgitation

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) 5 hours yrs. mos. ds.

(Signed) Bernard J. Curry M. D.

11-27, 1917. (Address) 889 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1000 Hollins

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Dec. 1, 1917

20-UNDERTAKER Joseph L. Cook ADDRESS 1003 W. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10425

CERTIFICATE OF DEATH.

D8 D10425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elnora Hanson

(Residence in Baltimore: No. 890 Linden Ave. St.; 80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day), — (Year)

7-AGE,	If LESS than 1 day,
80 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto-md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Arthur B. Lineburg

(Address) 24 W. Saratoga St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Nov 25 1917, that I saw h alive on above date 1917, and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia ?
Tuberculosis ?
Intestinal Hemorrhage
Pt unable to answer questions intelligently
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia ?
Pleurisy ?
(Duration) yrs. mos. 7 ds.

(Signed) H. H. Hammann M. D.

Nov. 28, 1917. (Address) Church Home Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 890 Linden Ave. Balt Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Pauls Cem.	Nov 29, 1917

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143 D10426

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward O. Deall

(Residence in Baltimore: No. 1009 W 37th.

St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, (Month) (Day) 1814 (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: 031
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Balt. R. R.

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward O. Deall

(Address) 1009 W. 37th. St.

15-

NOV 28 1917

Filed ....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1917, to Nov. 28, 1917, that I saw him alive on Nov. 28 1917, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

Uremia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(Duration) Unknown yrs. mos. ds.

(Signed) Alex D. Ley M. D.

11/28, 191.7 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 21 ds. In the State 4 yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 1009 N. 37th. St.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Dec. 1, 191.

20-UNDERTAKER Horace Burgee & Son

ADDRESS 733 Hollins Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10427 HEALTH DEPARTMENT—CITY OF BALTIMORE D10427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View Asylum St. ... WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludomb Guarasio,

(Residence in Baltimore: No. 335 Eastern Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Feb 12, (Month) (Day) 1873 (Year)

7-AGE, 44 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Antonia Guerasio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Elizabeth Mazzeo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Lolla

(Address) Lohr's Lane

15-

Filed NOV 29 1917, 191.... ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock
from Automobile
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 28 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Nov 29, 1917

20-UNDERTAKER E. W. Dill — ADDRESS 3109 Fredk ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 D10428

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Jones

(Residence in Baltimore: No. 1417 Bruce St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 41 yrs. ....mos. ....da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Servant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic 070

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Israel Jones

(Address) 1417 Bruce

15- NOV 29 1917 Filed....., 191.....

ROBERT B. KRAUTER Registrar.

Burial Permit 21871

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 26 1917, to November 27 1917, that I saw her alive on November 26 1917, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles E. Clark M. D.

Nov. 27, 1917. (Address) 1310 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Nov 29 191.7

20-UNDERTAKER P. Weil Eaton & Co

ADDRESS 916

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10429

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 D10429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 711 Bunne ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Agnes Cromwell.

(Residence in Baltimore: No. 711 Bunne St.; 85 yrs., 4 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, ~~OR DIVORCED,~~ (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Sunday (Month) 26 (Day), 1832 (Year)

7-AGE,	If LESS than 1 day,
85 yrs. 4 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. Pearson

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary A. Seddon

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Seddon Cromwell

(Address) 711 Bunne St

15- Filed NOV 29 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1916, to Nov 27. 1917, that I saw h.r alive on Nov 27 1917, and that death occurred, on the date stated above, at 4 1/2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Myocarditis.
Chronic Interstitial
Nephritis (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?
(Duration).....yrs.....mos.....ds.

(Signed) Charles V. Zimmerman M. D.

Nov 28, 1917. (Address) 1805 W North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	Dec 1st, 1917
20-UNDERTAKER Geo. W. Little	ADDRESS 531 N. Fremont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Geo. W. Mossop.

D10430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10430

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 302 E. Lanvale ST.: 11 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Mossop

(Residence in Baltimore: No. 302 E. Lanvale St.: 14 yrs., mos. ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.) Married

6-DATE OF BIRTH: April (Month) 1 (Day), 1861 (Year)

7-AGE: 56 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Jewelry Designer 038
(b) General nature of industry, business, or establishment in which employed (or employer): 942

9-BIRTHPLACE, (State or Country): Philadelphia Pa.

PARENTS.

10-NAME OF FATHER: Geo. Mossop

11-BIRTHPLACE OF FATHER (State or Country): England

12-MAIDEN NAME OF MOTHER: Susan Maloney

13-BIRTHPLACE OF MOTHER (State or Country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Mossop

(Address) 302 E. Lanvale

15- NOV 29 1917 Filed....., 191.....

ROBERT B. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Intracerebral hemorrhage

(b)

about 3 6 mos (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Tilly (Coroner.) M. D.

Nov 29, 191 7 (Address) 16 2 Bunsby

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Philadelphia Pa

DATE OF BURIAL: Nov 30, 1917

20-UNDERTAKER: Wm. Cook

ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10431

D10431

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Ruter ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Koleman

(Residence in Baltimore: No. 1426 Ruter St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Widower

6-DATE OF BIRTH, Don't Know 1869 ....., 7 .....
(Month) (Day) (Year)

7-AGE, 48 Don't Know yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter at
(b) General nature of industry, business, or establishment in which employed (or employer) Hotels

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Coleman

(Address) 1426 Ruter St.

15-

Filed NOV 29 1917, 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14th 191 , to Nov. 28th 191 ,
that I saw h— alive on Nov. 23rd 191 ,
and that death occurred, on the date stated above, at 1.20 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pulmonary

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Ellis M. D.

Nov 29, 1917 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. Mott Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10432

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D10432

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lindberg

(Residence in Baltimore: No. Univ Hospt St.; yrs., mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH, ..., 1840 (Month) (Day) (Year)

7-AGE, 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P.M. Lindberg

(Address) 403 W. Pratt St

15- NOV 29 1917

Filed....., 191....., Registrar.

ROBERT B. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-27-17, to 11-29-1917, that I saw h[im] alive on 11-29-1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis acute

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diphtheria Antitoxin

sclerosis (Duration) unknown yrs. mos. ds.

(Signed) B. B. Brumbaugh M. D.

11-29..., 1917. (Address) Univ Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 3 ds. In the State unknown yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown.

Former or usual residence 17 Elm St Curtis Bay, Md.

19-PLACE OF BURIAL OR REMOVAL, Cider Hill Cem. DATE OF BURIAL, Dec. 1..., 1917.

20-UNDERTAKER John Gobelian ADDRESS 425 S Paca St

D10433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D10433

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 649 N. Schroder ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Tucker

(Residence in Baltimore: No. 649 N. Schroder St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. 10, 1894 (Month) (Day) (Year)

7-AGE, 23 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer): 029

223

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Benj. F. Tucker

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Owens

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 339 S. Bolton

15- NOV 29 1917

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by gas

Fracture of skull

Laceration of brain

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

....., 191.7. (Address) 319 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Owensville A. A. Co. Md. DATE OF BURIAL, 11.30..., 191.7

20-UNDERTAKER J. Fen McCully ADDRESS 130 E. Fort Ave

D10431

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10431

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 604 Connell St. 20 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Beck

(Residence in Baltimore: No. 604 Connell St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Fem	Col.	Single

6-DATE OF BIRTH: Nov. 20, 1860 (Month) (Day) (Year)

7-AGE: 57 yrs. — mos. 7 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer): Private Family

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Jacob Brown

11-BIRTHPLACE OF FATHER (State or country): Va.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Watts

(Address) 604 Connell St

15-

Filed NOV 29 1917 ROBERT R. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1916, to Nov 27 1917, that I saw her alive on Nov. 26, 1917, and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY): Exhaustion

(Duration) ..... yrs. ..... mos. 2.1 ds.

(Signed), Frank E. Wagner M. D.

....., 191..... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Int Auburn Cemetery | DATE OF BURIAL: Nov 29, 1917

20-UNDERTAKER: Per H. Hoffman | ADDRESS: 1611 Gorsuch Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.; WARD)

REGISTERED NO. C 91 D10435

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Dunning

(Residence in Baltimore: No. 108 N. Green St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, October 18, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur G. Dunning

(Address) 108 N. Green St.

15- NOV 30 1917 Filed....., 191. ROBERT R. HEATON Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/27 1917, to 11/28 1917, that I saw h[er] alive on 11/28 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Collapse

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. 1 mos. 1 ds.

(Signed) Wm. F. Cluss M. D.

11/28, 191.7 (Address) Municipal, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 108 N. Green St

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER Harry H. Witzke — ADDRESS 1531 S. Lombard St

D10436 HEALTH DEPARTMENT—CITY OF BALTIMORE X 175 D10436

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Clarke Lane St.: 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Kaye.

(Residence in Baltimore: No. 225 Fairfield Ave St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Married

6-DATE OF BIRTH, May 3, 1860 (Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Concrete Work

9-BIRTHPLACE, (State or Country) Troy N.Y.

PARENTS.

10-NAME OF FATHER: John A. Kaye

11-BIRTHPLACE OF FATHER (State or Country): N.Y.

12-MAIDEN NAME OF MOTHER: Ann Connor

13-BIRTHPLACE OF MOTHER (State or Country): N.Y.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. R. F. Kaye

(Address) Balto Co

15-

NOV 30 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Coroner.

Nov 29 1917. (Address) 3602 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Troy N.Y. DATE OF BURIAL, Nov 30 1917

20-UNDERTAKER J. E. Hauck & Co. ADDRESS 2008 Allendale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10437

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 Myrtle Ave St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin F Pollard

(Residence in Baltimore: No. 233 Myrtle Ave St.; ..... yrs., 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colord	Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
45 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Shining

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, John R Pollard

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Ellen Hunter

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) His Wife Mary Pollard

(Address) 233 Myrtle Ave

15-

Filed NOV 30 1917 191.....

ROBERT B. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Nov 27 1917, that I saw h in live on Nov 27 1917, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) ..... yrs. 7 mos. 7 ds.

(Signed) John T Ewart M. D.

Nov 28, 1917. (Address) 1023 N Gay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Jaffaniie Va | DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER Wm R A Elliott | ADDRESS 506 East Jaffaniie

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY. CAUSE OF DEATH should be carefully stated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Franklin Sq Hosp St.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Chas Gist

(Residence in Baltimore: No. 814 N. Monroe St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June 5 (Month), 1883 (Day) (Year)

7-AGE, 34 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Gust

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Gust

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edith Gust

(Address) 814 N Monroe St

15-

Filed NOV. 30 1917, 191.... ROBERT R. KRAUTER Clerk.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Nov 28 1917, that I saw him alive on Nov 28 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Typhoid fever

(Duration) ....yrs. ....mos. 14 ds.

(Signed) Wade H. Kennerly M. D.

Nov 28, 1917. (Address) Franklin Sq Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 2 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 814 N. Monroe

19-PLACE OF BURIAL OR REMOVAL, Westminster Md — DATE OF BURIAL, Nov 30 1917

20-UNDERTAKER Geo A. Gerber — ADDRESS Balto Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH

Spec.—8-24-14—M. & T.—2000 Bks.

D10439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

110 D10439

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 947 N Wolf ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Muhlmichel

(Residence in Baltimore: No. 947 N Wolf St

St.; 61 yrs., 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug. 5 (Month) (Day) 1856 (Year)

7-AGE, 61 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Engel.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Muhlmichel

(Address) 947 N. Wolfe St

15- Filed NOV 30 1917, 191.... ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 27th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25th 1917, to Nov 27th 1917, that I saw her alive on Nov 27th 1917, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Fecal Impaction

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Auto Intoxication

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Elizabeth L. Russell M. D.

Nov 28th, 1917. (Address) 156 N. Milton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Nov. 30th, 1917.
20-UNDERTAKER	**ADDRESS**
Lilly & Zeller	403 S. Wolfe St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10440

CERTIFICATE OF DEATH. Cameron 92

D10440

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 610 Lanvale ST.; 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Cameron

(Residence in Baltimore: No. 610 Lanvale St.; 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1870 (Year)

7-AGE 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer) Private 896

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cameron

(Address) 1127 Argyle ave

15- NOV 30 1917

Filed ....., 191.... ROBERT H. [illegible]

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21st 1917, to Nov. 24th 1917, that I saw h[illegible] alive on Nov. 23rd 1917, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov 29, 1917, (Address) 1216 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 3 1917

20-UNDERTAKER [illegible]

ADDRESS 142 [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D10441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10441

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 W. Hill St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Jones

(Residence in Baltimore: No. 215 W Hill St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. ....., 1875
(Month) (Day) (Year)

7-AGE. 42 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar tender
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, S. Jones

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Julia Ewell

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Jones

(Address) 215 W. Hill St.

15-

Filed....., 191.....
Registrar.

ROBERT B. KRAUTER
Burial Permit Clerk
NOV 30 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1917, to Nov 27 1917, that I saw h[illegible] alive on Nov 20 1917, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. S. McCall M. D.

11/27, 1917 (Address) 2005 Division Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Nov 30, 1917.

20-UNDERTAKER J. H. Tradum

ADDRESS 1143 Mc Cul St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10442

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10442

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Columbia Ave St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Zimmermann

(Residence in Baltimore: No. 1235 Columbia Ave St.: 31 yrs.. ..mos..ds.)

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. 11 (Month) (Day), 1853 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 11 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, William Meister

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude M. Jones

(Address) 5096 W. Hamburg St

15-

Filed 1917 OCT 20 ROBERT R. KRAUTHOFF Burial Permit Clerk

....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 191.., to Nov 27 1917, that I saw h.. alive on Nov 27 1917, and that death occurred, on the date stated above, at 2.55 P.m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

..... (Duration) ....yrs. ....mos. 7 ds.

(Signed) Edw. Green M. D.

Nov 17, 191.. (Address) 502 Lan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Nov 20 191.7

20-UNDERTAKER Wm. Mo Jo n N. Temple ADDRESS 801 N. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10443

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Saratoga ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Kuehn.

(Residence in Baltimore: No. 811 N. Saratoga St.; 22 yrs., — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) married

6-DATE OF BIRTH, April 7, 1857. (Month) (Day) (Year)

7-AGE, 60 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Lancaster Ohio

PARENTS.

10-NAME OF FATHER, Paul Kalb

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emilia Conrad

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Kuehn

(Address) 811 N. Saratoga St

15-

Filed, NOV 30 1917, 191.... ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22. 1917, to Nov. 28 1917. that I saw h[er] alive on Nov. 28th 1917, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) — yrs. — mos. 2 ds.

(Signed) Geo W Hemmeter M. D.

Nov 28, 1917. (Address) 500 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Pauls Luth Cmtry. DATE OF BURIAL, Nov 30, 1917.

20-UNDERTAKER Mrs A Rohde Sons ADDRESS 730 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10447

CERTIFICATE OF DEATH.

REGISTERED No. C 4 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N Pearl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Dorsey

(Residence in Baltimore: No. 111 N Pearl St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1866 (Year)

7-AGE, 49 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md,

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Henson

(Address) 111 N. Pearl

15-

NOV 30 1917

Filed ....., 191.... ROBERT R. KRAUTER

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 13 1917, to Nov 27 1917, that I saw h er alive on Nov 27 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Valvular Disease

(Duration) ....yrs. 6 mos. ....ds.

(Signed) William C Burton M. D.

Nov 28, 191.7 (Address) 762 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Nov 30 1917

20-UNDERTAKER, C. Charles B. Jones — ADDRESS 236 Park Ave

D10445 HEALTH DEPARTMENT—CITY OF BALTIMORE D10445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 620 Pine alley ST.: 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nanna Butler

(Residence in Baltimore: No. 620 Pine alley St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, ..., 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Butler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Daisy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Butler

(Address) 620 Pine alley

15- Filed NOV 30 1917, 191.. ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Driscoll M. D.
(Coroner.)

Nov 29, 1917. (Address) 1211 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sauerd tents DATE OF BURIAL, Nov 30, 1917

20-UNDERTAKER Charles B Jones ADDRESS 235 N Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10446

D10446

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 E. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Harrison

(Residence in Baltimore: No. 1026 E. Lombard St.: 24 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS DATA BECOMES A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 65 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Harrison

(Address) 1026 E Lombard St

15-

NOV 30 1917

Filed ....., 191.....

ROBERT R. KRAUTER
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1917, to Nov. 29 1917, that I saw her alive on Nov. 29 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

Cardiac Insufficiency

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(Duration) yrs. mos. ½ ds.

(Signed) D. G. Mc Culloch M. D.

Nov. 30, 1917 (Address) 1510 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1026 E Lombard St

19-PLACE OF BURIAL OR REMOVAL, Holmes Burying Ground

DATE OF BURIAL, Nov. 30, 1917.

20-UNDERTAKER L. Grinnan & Co.

ADDRESS 1107 E Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D10447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10447

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 N. Milton ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Hamilton

(Residence in Baltimore: No. 445 N. Milton ave St.; 72 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Aug (Month) 12 (Day), 1845 (Year)

7-AGE: 72 yrs. 3 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Richard Hamilton

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER, Caroline Vernon

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eva S. Thompson

(Address) 445 N. Milton ave

15-

Filed NOV 30 1917 191..

ROBERT R. KRAUTER
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1917, to Nov. 28, 1917, that I saw h[illegible] alive on Nov. 28, 1917, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Endarteritis assoc. Cardiac Hypertrophy

(Duration) 2 yrs. mos. ds.

(Signed) Robert J. Green M. D.

Nov 29, 1917. (Address) 120½ Dis[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Patto Cemetery

DATE OF BURIAL, Nov 30 1917

20-UNDERTAKER Josiah Syfer

ADDRESS 1000 W Mart[illegible] ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10448

CERTIFICATE OF DEATH.

28 D10448

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S Chester St.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred E. Kistner

(Residence in Baltimore: No. 235 S. Chester St.; 6/12 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April 16, 1901 (Month) (Day) (Year)

7-AGE, 16 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at school
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, August Kistner

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Cecilia Thistle

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Kistner

(Address) 235 S Chester St

15- Filed NOV 30 1917, 191.. ROBERT R. KRAUTER Burial Permit ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1917, to Nov 27 1917, that I saw her alive on Nov 26 1917, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. 27 ds.

CONTRIBUTORY (Secondary) Cy Hamilton

(Duration) yrs. 1 mos. ds.

(Signed) Cyrus D Atkins M. D.

Nov 29, 1917 (Address) 6 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 1, 1917

20-UNDERTAKER H. Sander & Sons — ADDRESS 17 N Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10449

CERTIFICATE OF DEATH.

28 D10449

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Pressbury St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. John Laverty

(Residence in Baltimore: No. 2002 Pressbury St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, February 1st, 1895
(Month) (Day) (Year)

7-AGE, 22 yrs. 8 mos. 27 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Business

9-BIRTHPLACE, (State or Country), New York City

PARENTS.

10-NAME OF FATHER, Saml. L. Laverty

11-BIRTHPLACE OF FATHER (State or Country), New York City

12-MAIDEN NAME OF MOTHER Nettie Sauls

13-BIRTHPLACE OF MOTHER (State or Country), New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nettie Laverty

(Address) 2002 Pressbury St.

15- Filed NOV 30 1917, 19.....

ROBERT E. KRAUTER
DEPUTY REGISTRAR

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1st 1917, to Nov 28 1917, that I saw h[im] alive on Nov 28th 1917, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Wm. J. Sullivan M. D.

Nov 28th, 1917 (Address) 1701 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Catonsville | DATE OF BURIAL, Dec 1, 1917

20-UNDERTA[illegible] Cook | ADDRESS 1126 North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10450

CERTIFICATE OF DEATH.

79 D10450

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 N. Franklin ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha F. Reisner

(Residence in Baltimore: No. 1421 N. Franklin St. Lifty-five yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov 29 1862 (Month) (Day) (Year)

7-AGE, About 65 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Wagner

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Harriet Foy

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Whelan

(Address) 1421 N. Franklin St

15-

Filed NOV 30 1917, 191..., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1917, to Nov 29 1917, that I saw her alive on Nov 29 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Duration 7 mos.

CONTRIBUTORY (Secondary) None

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) Henry C. Dilg M. D.

Nov 29, 1917. (Address) 1203 N. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 1, 1917

20-UNDERTAKER William Cook — ADDRESS 501 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10451

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 Sulgerord St.; 13 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. S Young.

(Residence in Baltimore: No. 720 Sulgerford ave St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Aug 19, 1917
(Month) (Day) (Year)

7-AGE, 62 yrs. 8 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 062

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Harid Young

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER McKinnon

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Young

(Address) 720 Sulgerford Ave

15- NOV 30 1917 ROBERT B. [illegible]

Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey M. D.
(Coroner.)

Nov 30 1917 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Granite Balto Md

DATE OF BURIAL, Dec. 1, 1917

20-UNDERTAKER Chenoweth Son

ADDRESS Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10452

D10452

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4010 Church St. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin L. Kilroy

(Residence in Baltimore: No. 4010 Church St. St.; 47 yrs., 7 mos. 3 ds.)

N. B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH. April 26, 1870 (Month) (Day) (Year)

7-AGE. 47 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Black Smith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Patrick Kilroy

11-BIRTHPLACE OF FATHER (State or Country). Irland.

12-MAIDEN NAME OF MOTHER. Julia Burke.

13-BIRTHPLACE OF MOTHER (State or Country). Irland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Kilroy Jr.

(Address) 4010 Church St.

15- NOV 30 1917 Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Nov 29 1917, that I saw h[e] alive on Nov. 29 1917, and that death occurred, on the date stated above, at 1255 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis Interstitial

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis Chronic

(Duration) 1 yrs.....mos.....ds.

(Signed) Vernon D. Healy M. D.

Nov 29th, 1917. (Address) 3703 Falls Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Mary Govans

DATE OF BURIAL. Dec 1, 1917

20-UNDERTAKER Dulworth & Son

ADDRESS 407 Cathedral

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10453

D10453

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH U. S. Marine Hospital

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Lawton

(Residence in Baltimore: No. U. S. Marine Hospital ...yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word)
Male	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.

9-BIRTHPLACE, (State or Country), La.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. Hospital record

(Informant) .....

(Address) .....

15- Filed NOV 30 1917 191.. ROBERT B. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 191 7 to Nov 28 1917, that I saw h.. alive on Nov 28 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

.....

Tuberculosis Dis

.....

Pulmonary (Complete stop)

..... (Duration) yrs. 5 mos. 2 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) yrs. ..... mos. ..... ds.

(Signed) Chas. E. Wood M. D.

Nov 29, 191.. (Address) U. S. Marine Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 2 ds. In the State yrs. 5 mos. 2 ds.

Where was disease contracted, if not at place of death? sea

Former or usual residence La.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	Dec. 3, 191..
20-UNDERTAKER Wenworth & Son	ADDRESS 3617 Chestnut Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10451

D10451

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 St Paul St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Armiger

(Residence in Baltimore: No. 2733 St Paul St. St.; ....yrs.,....mos.....dz.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 17, 1837
(Month) (Day) (Year)

7-AGE, 80 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md City

PARENTS.

10-NAME OF FATHER, Jos Armiger

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Julia Lash

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J R M Stevens

(Address) 2733 St Paul St

15- NOV 30 1917 Filed....., 191. ROBERT E. PRUTTH Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1917 to Nov 28 1917, that I saw h-- alive on November 27 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

Many years.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

Nephritis (Duration) ....yrs. ....mos. ....ds.

(Signed) David B Custer M. D.

Nov 28, 1917. (Address) 9 W Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Nov 30, 191...

20-UNDERTAKER W B Purdum Sons

ADDRESS Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D Custer 9 W Chase

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10455

CERTIFICATE OF DEATH.

40 D10455

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N. Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Otto Kroencke

(Residence in Baltimore: No. 1629 N. Monroe St.; 25 yrs. — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov. (Month) 13th (Day), 1858 (Year)

7-AGE,	If LESS than 1 day,
59 yrs. — mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance 071
(b) General nature of Industry, business, or establishment in which employed (or employer): Solicitor 630

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Alfred H. Kroencke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Stein

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Kroencke

(Address) 1629 N. Monroe St.

15- ROBERT R. KRAUTH

Filed NOV 30 1917 191.. Senior Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1915, to Nov. 29 1917, that I saw h[illegible] alive on Nov. 29 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) K. C. Metzel M. D.

Nov. 29, 1917. (Address) 1903 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Nov. 191.7
20-UNDERTAKER	ADDRESS
903 Pleasant	1736 Eutaw Pl

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10456

CERTIFICATE OF DEATH.

79 D10456

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Noeth

(Residence in Baltimore: No. St Joseph's Hospital St.; 67 yrs., — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) ..., 1850 (Year)

7-AGE: 67 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): Work

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: John Noeth

11-BIRTHPLACE OF FATHER (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Michael

(Address) 844 W Fayette St

15-

Filed NOV 30 1917, 191...

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1917, to Nov 29 1917, that I saw her alive on Nov 29 1917, and that death occurred, on the date stated above, at 7.50 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

several years

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) ... yrs. ... mos. 20 ds.

(Signed) H. Merkel M. D.

Nov 29, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 56 yrs. ... mos. ... ds. In the State Life yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence St Josephs Hosp

19-PLACE OF BURIAL OR REMOVAL, St Helens Cem

DATE OF BURIAL, Dec 1st, 1917.

20-UNDERTAKER John F Leaman & Son

ADDRESS 920 Hollins St

Spec.—6-19-13—M. & T.—600 Blks.

D10457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10457

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Harlem Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Edward Florence Polster

(Residence in Baltimore: No. 1108 Harlem Ave St.: ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, August 20th (Month) (Day), 1866 (Year)

7-AGE, 51 yrs. 3 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 090

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Ferdinand Polster

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth A Dudley.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Howard Taylor M.D.

(Address) 204 N Gonden Ave

15- ROBERT R. KRAUTER

Filed NOV 30 1917 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 191.., to Nov 28th 191.., that I saw her alive on Nov 28th 191.., and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) ....yrs. 5 mos. ....ds.

(Signed) E. Howard Taylor M. D.

Nov 29, 191.. (Address) 204 N Gonden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 1, 1917.

20-UNDERTAKER Geo J Smith

ADDRESS 100 W Fayette

D10458

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10458

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 120 E. Gilling St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Church

(Residence in Baltimore: No. 120 E Gilling St. 43 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb. (Month) 20 (Day), 1874 (Year)

7-AGE: 43 yrs. 9 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Fred. Schubert

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Dorn

(Address) 120 E Gilling St

15-

Filed NOV 30 1917, 191

ROBERT R. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov. (Month) 28 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept., 191 7, to Nov 28 1917, that I saw h[er] alive on Nov 28, 191 7, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia (Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Chronic Nephritis (Duration) ..... yrs. 6 mos. ..... ds

(Signed) C. Wm Miller M. D.

Nov 28, 1917 (Address) 1279 Williams St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Nov. 30, 1917

20-UNDERTAKER: M. A. Flynn ADDRESS: 1422 Light St.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PRESERVE FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10459

CERTIFICATE OF DEATH.

120 D10459

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Westwood Ave., ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Bergen,

(Residence in Baltimore: No. 1619 Westwood Ave., St.; 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown, (Month) ..... (Day) 1 (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None,
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, unknown,

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bergen,

(Address) 1619 Westwood Ave.

15-

Filed ....., 191.... ROBERT P. KRAUTER Registrar.

NOV 30 1917 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 28th. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1916, to Nov 28 1917, that I saw h[illegible] alive on Nov. 28 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Heart Disease

Chronic (Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobularis

(Duration) 1 yrs. mos. ds.

(Signed) Thomas Fulton M. D.

Nov 29, 1917. (Address) 1001 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oheb Shalom

DATE OF BURIAL. Nov. 30th, 1917

20-UNDERTAKER David Goudelman

ADDRESS 118 W. Mt. Royal Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10460

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D10460

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Bruce ST.; 17 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Massey

(Residence in Baltimore: No. 529 Bruce St. St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 25, 1876 (Month) (Day) (Year)

7-AGE, 31 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hotel
(b) General nature of industry, business, or establishment in which employed (or employer)..... Waiter 086

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, James F Massey

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Annie Bishop

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Massey

(Address) 2078 Brunt St

15-

Filed NOV 30 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1917, to Nov 28 1917, that I saw h.. alive on Nov 27 1917, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Kreckel M. D.

11/28, 191.7. (Address) 1111 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 1, 191.7.

20-UNDERTAKER Geo A Holland ADDRESS 631 D Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D1046E

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1046E

CERTIFICATE OF DEATH.

REGISTERED NO. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur C. Gibson

(Residence in Baltimore: No. 707 Brewer St

St.: yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May 1, 1906 (Month) (Day) (Year)

7-AGE, 11 yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Arthur C. Gibson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Stella Pfeil

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Smith

(Address) Johns Hopkins Hospital

15-

Filed NOV 30 1917 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1917, to Nov. 30 1917, that I saw h— alive on Nov. 30 1917, and that death occurred, on the date stated above, at 5 10 a— m.

The CAUSE OF DEATH* was as follows:

Meningitis Acute

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Cyst (Operation)

(Duration) 7 yrs. mos. ds.

(Signed) W. E. Thrush M. D.

Nov. 30, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 707 Brewer St

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Charles E. Francke ADDRESS 602 Madison Ave

D10462 HEALTH DEPARTMENT—CITY OF BALTIMORE D10462

CERTIFICATE OF DEATH.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 817 Lemmon ST.: 18 WARD) REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Fletcher

(Residence in Baltimore: No. 817 Lemmon St.: yrs., 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Oct. 14th, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Norman Fletcher

11-BIRTHPLACE OF FATHER (State or Country) Balto Md.

12-MAIDEN NAME OF MOTHER Frances Lang

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Norman Fletcher

(Address) 817 Lemon St

15- FILED NOV 30 1917, 191 ROBERT R. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition caused by Congenital Cardiac malformation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Driscoll M. D. (Coroner)

Nov 30, 1917 (Address) 211 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Nov 30th 1917

20-UNDERTAKER John Flowers Son ADDRESS 901 Hollins St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10463

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Edmondson Av. ; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes P. Donnelly

(Residence in Baltimore: No. 832 Edmondson Av. ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 23 (Day) 1843 (Year)

7-AGE, 74 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Donnelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Donnelly

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kelly

(Address) 832 Edmondson Av

15-

NOV 30 1917

Filed ....., 191.... ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28 191 7, to Nov 29 191 7, that I saw her alive on Nov 28 191 7, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Hypostatic)

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) William E. Burns M. D.

Nov 29, 191 7. (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 12 1, 191 7.

20-UNDERTAKER H. C. Branning & Son

ADDRESS 517 N. Schroeder St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10464

CERTIFICATE OF DEATH.

126

D10464

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 S. Bond. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. Jeserik.

(Residence in Baltimore: No. 927 S. Bond. St.; 38 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. Whit

5-CONDITION. (Write the word.) Married

6-DATE OF BIRTH, Mar. (Month) 29 (Day), 1836 (Year)

7-AGE, 81 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): General.

9-BIRTHPLACE, (State or Country), Germany Poland

PARENTS.

10-NAME OF FATHER, Frank Jeserik

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jeserik

(Address) 2030 Bank St

15- NOV 30 1917 ROBERT P. KRAUTER Registrar

Filed ..... 191 .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 29th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Nov 29 1917, that I saw him alive on Nov 26 1917, and that death occurred, on the date stated above, at 8 PM m.

The CAUSE OF DEATH* was as follows:

Acute retention of Urine

following the administration of drawing off Urine Catheter

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) old age + partial Occl. of bowels

(Duration) yrs. mos. 2 ds.

(Signed) R. T. Hardy M. D.

Nov 30 1917. (Address) 1930 Bank St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mos. ds. In the State ..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Dec 1, 1917.

20-UNDERTAKER William Fischeski

ADDRESS 618 Eastern Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10465

D10465

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 615 Pierce ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Green

(Residence in Baltimore: No. 615 Pierce St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1917 (Year)

7-AGE, ...yrs. 1 mos. .....ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Richard Green

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Lucy Alexander

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Green

(Address) 615 Pierce St

15- ROBERT P. KRAUTER

Filed NOV 30 1917 191... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) A. D. Driscoll M. D.
(Coroner)

Nov 29 191 7 (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Nov 30 1917
20-UNDERTAKER John H. Taden	ADDRESS 142 Mosher Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10466

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2526 Woodbrook ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George M. Hertzell

(Residence in Baltimore: No.) 2526 woodbrook St.: Wf yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: Sept (Month) 2 (Day), 1917 (Year)

7-AGE: ... yrs. 4 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Child (b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: William E Hertzell

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Ethel J Loyd

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E Hertzell

(Address) 2526 Woodbrook

15-

Filed NOV 30 1917 191... ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Nov 30 1917, that I saw h alive on Nov 30 1917, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

From chronic rheumatism

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Mal nutrition

(Duration) ... yrs. ... mos. 3 ds.

(Signed) ... M. D.

Nov 30, 191... (Address) 1303 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Dec 1, 1917.

20-UNDERTAKER: William Cook

ADDRESS: 507 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D10167

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10167

CERTIFICATE OF DEATH

REGISTERED No. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Homestead ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E Donahue

(Residence in Baltimore: No. 1733 Homestead St.; 38 yrs. 3 mos. 28 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July (Month) 30 (Day), 1879 (Year)

7-AGE: 38 yrs. 3 mos. 28 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Captain 086
(b) General nature of industry, business, or establishment in which employed (or employer): Fire Department

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lula K. Donahue

(Address) 1733 Homestead St.

15- Filed NOV 30 1917 ROBERT B. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6, 1917, to, Nov 28 1917, that I saw him alive on Nov 28 1917, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 4 yrs ... mos. ... ds.

Contributory (SECONDARY): Paralysis -

(Duration) 4 yrs mos. ds.

(Signed) Fritz J. Kinzey M. D.

Nov 29, 1917 [Address] 2700 Hereford Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Dec. 1st, 1917

20-UNDERTAKER: E. Schlosman & Son ADDRESS: 1039 Hanover St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D10468

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 N Fayette ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M Eckle

(Residence in Baltimore: No. 1842 N Fayette St St.; ...yrs., ...mos. ...ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, March 17, 1857
(Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Fahey

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Eckle

(Address) 2140 W. Fayette

15-

Filed NOV 30 1917, 191... ROBERT R. KRAUTH Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 1916, to Nov 28 1917, that I saw h— alive on Nov 28 1917, and that death occurred, on the date stated above, at 10h 1m.

The CAUSE OF DEATH* was as follows:

Diabetes
Chronic Interstitial Nephritis

(Duration) 9 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 2 ds.

(Signed) E. V. Cockburn M. D.

11/29/17, 191... (Address) 24 N Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Catholic Cem

DATE OF BURIAL, 12/1..., 191...

20-UNDERTAKER George C Farley

ADDRESS Fulton & Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10469 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10469

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. 808 E Monument St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Schmidt

(Residence in Baltimore: No. 808 E Monument St.; 62 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem | 4-COLOR OR RACE. W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH March 29, 1855 (Month) (Day) (Year)

7-AGE. 62 yrs. 8 mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Christopher Maszey

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Herman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H C Schmidt

(Address) 808 E Monument St

15-

Filed NOV 30 1917 191 ROBERT R. TRAUTEN (Clerk)

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1916, to Nov 28 1917, that I saw h alive on Nov 28 1917, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

a Stroke

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) H C Schmidt M. D.

Nov 30, 1917. (Address) 839 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL Laurel Park Cem. DATE OF BURIAL, 12/1, 1917.

20-UNDERTAKER Harry H Wetzke ADDRESS 1531 W Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10470

CERTIFICATE OF DEATH.

29 D10470

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Keyworth & Green Spring Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Walter Shirley

(Residence in Baltimore: No. Keyworth & Green Spring Avs., St.; About 60 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, February (Month) 17 (Day), 1861 (Year)

7-AGE, 56 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired.
(b) General nature of industry, business, or establishment in which employed (or employer): (none)

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Shirley.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Ellen Fraser.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. MaudeD. Shirley (wife)

(Address) Keyworth & Green Spring Av

15- Filed NOV 30 1917, 191... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Nov 24 1917, that I saw h.. alive on Nov 24 1917, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) ....yrs. ....mos. ....ds.

(Signed) Leo A Brockman M. D.

Nov 29 1917 (Address) 2200 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery.	Dec. 1/17 191...
20-UNDERTAKER	ADDRESS
Stewart & Mowen Company	108W. North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10471

CERTIFICATE OF DEATH.

D10471

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protest. Infirmary ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazeltine Houck

(Residence in Baltimore: No. Corbet, Md. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... April (Month) 4 (Day), 1872 (Year)

7-AGE, 45 yrs. 7 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Houck

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Frances Porter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. R. Micklethwaite

(Address) U. P. H.

15- ROBERT R. KRAUTER

Filed NOV 30 1917 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1917, to Nov 29 1917, that I saw h im alive on Nov 29 1917, and that death occurred, on the date stated above, at 2:02 p.m.

The CAUSE OF DEATH* was as follows:

Pelvic abscess
Operation Nov 26 1917
OVW

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Peritonitis, myocard
Insuff & dilatation (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. R. Micklethwaite M. D.

Nov 29, 1917 (Address) U. P. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ? yrs. ? mos. 4 ds. In the State 45 yrs. 7 mos. 25 ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence Corbet Md

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER Stewart & Co — ADDRESS 108 W. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10172

CERTIFICATE OF DEATH.

D10172

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Stellington ST.; Hampden 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Ayler (Ayler)

(Residence in Baltimore: No. 814 Stellington St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 20, 1864 (Month) (Day) (Year)

7-AGE, 53 yrs. 7 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel H. Cox

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Ports

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Ayler

(Address) 814 Hellington St.

15-

Filed NOV 30 1917, 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Nov 30 1917, that I saw her alive on Nov 29 1917, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Immun. 1 the Kidneys

Hypostatic Pneumonia

one

8 (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contus

(Duration) yrs. mos. ds.

(Signed) Geo. E. Brouck M. D.

Nov 30, 1917. (Address) 512 W Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Horace Burgee & Son — ADDRESS 323 Falls Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10478

CERTIFICATE OF DEATH.

X 104 D10478

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mitchell Morris Jr.

(Residence in Baltimore: No. Wylie Ave St.; yrs., 4 mos. 6 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1917 (Year)

7-AGE, ...yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 D

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Mitchell Morris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Edith R Isaac

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... M Morris

(Address) Johns Hopkins Hospital

15- NOV 30 1917 ROBERT R. KRAUTER
Filed....., 191..... Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 27 191, to Nov 30 191, that I saw h alive on Nov. 30 191, and that death occurred, on the date stated above, at 12 p m.

The CAUSE OF DEATH* was as follows:

gastro-intestinal indigestion.

..... (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration) ....yrs. 2 mos. ....ds.

(Signed) J. M. Rivers M. D.

Nov 30, 191. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Wylie Ave

19-PLACE OF BURIAL, OR REMOVAL, Cathedral Cemetery DATE OF BURIAL, Dec 3, 191.

20-UNDERTAKER Horace Burgee & Son ADDRESS 3631 Fallsway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10471

CERTIFICATE OF DEATH.

x92

D10471

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 424 W. Biddle St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlie Annie Best

(Residence in Baltimore: No. 424 W. Biddle St.; yrs., 6 mos. ds.)

WRITE PLAINLY, WITH USFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. Black | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, March 15, 1900 (Month) (Day) (Year)

7-AGE, 17 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) 800

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Alex Best

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Nancy Carter

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Best

(Address) 424 Biddle St.

15- DEC 1 - 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23 1917, to Nov. 29 1917, that I saw her alive on Nov. 27 1917, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 5 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Montague M. D.

Nov. 30, 1917. (Address) 303 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. mos. ds. In the State 6 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence N.C.

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery | DATE OF BURIAL, Dec 1, 1917

20-UNDERTAKER John A. Disney | ADDRESS 110 N. Eden Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10475

CERTIFICATE OF DEATH.

28 ✓ D10475

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1162 E. North Ave ~~(St.)~~ 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie V. Gutridge.

(Residence in Baltimore: No. 1162 E. North Ave. St.: 28 yrs., 6 mos. 14 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 14 (Month) (Day), 1889 (Year)

7-AGE, 28 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Trainor

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Margt. Beatty

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. P. Gutridge

(Address) 1162 E. North ave.

15- Filed DEC 1 - 1917, 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 191 7 to Nov 28 191 7, that I saw h[er] alive on Nov 28 191 7, and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Brain

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(Duration) ....yrs. 1 mos. 3 ds.

(Signed) Edw. L. Fellows M. D.

Nov 30, 191 7 (Address) 2042 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Dec 1st, 1917.

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Spec—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10476

CERTIFICATE OF DEATH,

92 D10476

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Carey ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Donnelly Sr.

(Residence in Baltimore: No. 231 N. Carey St.; St.; 61 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept. 17, 1856 (Month) (Day) (Year)

7-AGE, 61 yrs. 2 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Kilburn

(Address) 104 S. W. Mulberry

15-

Filed DEC 1 1917, 191 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1917, to Nov 30 1917, that I saw h[er] alive on Nov 29 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

1 Bron Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Contd

(Duration) yrs. mos. ds.

(Signed) T. McNamara M. D.

Dec 1, 1917. (Address) 901 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonni Brae

DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Geo. J. Smith

ADDRESS 1000 W. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D10477

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Womens Home St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. Warner

(Residence in Baltimore: No. 1402 W Lexington St.; 75 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Feb 10 (Month) (Day), 1842 (Year)

7-AGE, 75 yrs. 9 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Bacto.

PARENTS.

10-NAME OF FATHER, Medist Warner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Julia A Rogers

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella F Jones

(Address) Matron

15-

Filed DEC 1 1917 191.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 191 7, to Nov 30 1917, that I saw h alive on Nov 30 1917, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 30, 1917. (Address) 739 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. ds. In the State yrs. 2 mos. ds.

Where was disease contracted if not at place of death? Aged Womens Home

Former or usual residence Aged Womans Home

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 3, 1917.

20-UNDERTAKER George J Smith

ADDRESS 1000 N. Fayette St

Spec.—8-24-14—M. & T.—2000 Blks.

D10478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10478

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 744 E Preston ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie G. Johnston

(Residence in Baltimore: No. 744 E. Preston St.: 66 yrs., — mos., — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov 1 (Month) (Day) (Year)

7-AGE, 66 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Patrick Feehan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Lafferty

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Feehan

(Address) 744 E Preston St

15-

DEC 1 - 1917

Filed....., 191.. ROBERT E. KRAUTER Registrar.

Burial Permit Clerk

8

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Nov 30 1917, that I saw h er alive on Nov 30 1917, and that death occurred, on the date stated above, at 7 10 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurg. and Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 7 ds.

(Signed) Edw J Blake M. D.

Nov 30, 1917. (Address) 70 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Henry Houck Son

ADDRESS 1301 E Eager

D10479 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10479

CERTIFICATE OF DEATH.

X 170

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Kinder

(Residence in Baltimore: No. Early Heights St.: yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, February 19, 1887 (Month) (Day) (Year)

7-AGE, 30 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, William Kinder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henrietta Mackinsky

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav Kinder

(Address) Early Heights

15- DEC 1 - 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia, and Hemorrhage caused by Gun shot wounds in Chest (accidental)

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) A. D. Driscoll M. D. (Coroner)

Nov 30, 1917 (Address) 121 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS): At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Elmwood Cemetery — DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER, Thompson & Dumler — ADDRESS 715 E. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Old 2900
D10480

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 ✓ D10480

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 905 Pendle Ct ST: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Danny Dent

(Residence in Baltimore: No. 905 Pendle Ct St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct. (Month) 19 (Day), 1877 (Year)

7 AGE: 40 yrs. 1 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: James Dent

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sophie (illegible)

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Horace Dent

(Address) .....

15 Died DEC 1 - 1917, 191 .....

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 30 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1917, to Nov. 30 1917, that I saw him alive on Nov. 30, 1917, and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Ac. Enteritis

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), [redacted] Frank B. Wagner M. D.

Dec, 191 7 (Address) 1206 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. 7 mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 3, 191 7

20 UNDERTAKER: Wade Ecker — ADDRESS: 916 Park Ave

S

Dcc.—8-24-14—M. & T.—2000 Bks.

D10481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10481

CERTIFICATE OF DEATH.

+31

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles S Thomas

(Residence in Baltimore: No. 22 S 2nd St Brooklyn Md St.; yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... July (Month) 8 (Day), 1874 (Year)

7-AGE, 43 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Thomas

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15- Filed DEC 1 - 1917, 191.... ROBERT R. REUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1 191 7, to November 29 191 7, that I saw h living alive on November 29 191 7, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

1 Tuberculous Stomach

2 General Tuberculosis

3

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulcer Stomach

(Duration) yrs. 6 mos. ds.

(Signed) W E Darby M. D.

Nov 29, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 29 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? (

Former or usual residence 22 S 2nd St Brooklyn

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cy DATE OF BURIAL, Dec 3, 191 7

20-UNDERTAKER Jos Joerdens Son ADDRESS 2173 E Pres.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10182

CERTIFICATE OF DEATH.

10 D10182

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline L. Arlow

(Residence in Baltimore: No. Home for Incurables St.; 70 yrs., ? mos., ? ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. October (Month) 15 (Day), 1847 (Year)

7-AGE, 70 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Andrew Arlow

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary Catherine Barton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie S. Clarke (sister)

(Address) 1609 E. Biddle St.

15-

Filed DEC 1 1917, 191.....

ROBERT B. KRAUTER
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25 1917, to Nov. 28 1917, that I saw h.. alive on Nov 28 1917, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure 15 min

Arthritis Deformans

(Duration) 7 yrs. ? mos. 15 min

(Signed) Walter L. Bacon M. D.

Nov. 28, 1917 (Address) 100 E. 20th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec. 1, 191?

20-UNDERTAKER H. E. Hughes

ADDRESS 17 S. Broadway.

Spec.—8-24-14—M. & T.—2000 Bks.

D10183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 ✓ D10183

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 N. Bond ST.; 8 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Emily Lewis

(Residence in Baltimore: No. 1530 N. Bond St.; ....yrs., mos. ds.)

N. B.—THIS IS A PERMANENT RECORD AND IS PRINTED, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April 13, 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Bailey

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Ann Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Randle Lewis

(Address) 1611 E. Preston St.

15-

Filed DEC 1 1917, 191... ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1917, to Nov. 30 1917, that I saw her alive on Nov 30 1917, and that death occurred, on the date stated above, at 1.02 P.m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia & Angina

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. E. Lewis M. D.

Dec 1, 191... (Address) 1412 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec 3, 191...

20-UNDERTAKER W. E. Hughes

ADDRESS 1 S. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D10481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D10481

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Patterson Park ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Fehsenfeld.

(Residence in Baltimore: No. 230 S Patterson Park ave, St.; 85 yrs., 8 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, March 12, 1832.
(Month) (Day) (Year)

7-AGE, 85 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Jenever, Germany.

PARENTS.

10-NAME OF FATHER, Luhr Fehsenfeld,

11-BIRTHPLACE OF FATHER (State or Country), Jenever Germany,

12-MAIDEN NAME OF MOTHER Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louisa Foster (daughter)

(Address) 230 S Patterson Park ave.

15- DEC 1 - 1917 ROBERT R. KRAUTER

Filed....., 191.... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13 1915, to Nov 30 1917, that I saw him alive on Nov. 28 1917, and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Arthur L. Fehsenfeld M. D.

Nov. 30, 1917. (Address) 2306 Garrison Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER John D. Mitchell ADDRESS 1201 W Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS CERTIFICATE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10485

CERTIFICATE OF DEATH

64 ✓ D10485

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 616 Lennox St.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Klingelhöfer.

(Residence in Baltimore: No. 616 Lennox St.: 68 yrs. 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6-DATE OF BIRTH December 5th, 1848
(Month) (Day) (Year)

7-AGE 68 yrs. 11 mos. 24 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Baltimore, Md.

PARENTS

10-NAME OF FATHER Georg Friedrich Koch.

11-BIRTHPLACE OF FATHER (State or country) Germany.

12-MAIDEN NAME OF MOTHER Barbara Ebeling.

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. C. Klingelhöfer

(Address) 616 Lennox St.

15 [illegible] Burial Permit Clerk

Filed DEC 1 - 1917 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH November 29, 191 7
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 17th, 1917, to November 29th 1917, that I saw her alive on November 29th, 1917, and that death occurred, on the date stated above, at 1.55 P. m.
The CAUSE OF DEATH* was as follows:

Hemiplegia. Apoplexy

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Wm Conrad Bode M. D.

Nov 30th, 1917. (Address) 1900 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Dec 1, 1917

20-UNDERTAKER John O. Uttle Hell | ADDRESS 120 W. Fayette

D10486 HEALTH DEPARTMENT—CITY OF BALTIMORE D10486

155

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B Taylor

(Residence in Baltimore: No. Josephine Ave Arch St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, August 23, 1891
(Month) (Day) (Year)

7-AGE, 26 yrs. 3 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boot black. 813
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Elijah Taylor

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Maria Jamerson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital Records

(Address) Gorm & Lombard.

15-

Filed DEC 1 1917, 191 ROBERT B. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hg. Chloride, ? Mercury. (Poisoning) probable Suicide.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. ....mos. ....ds.

(Signed) A O'Driscoll M. D.
(Coroner)

Nov. 30 1917. (Address) 1211 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec. 3, 1917.

20-UNDERTAKER Felix B. Pyle ADDRESS 102 E. Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10187

CERTIFICATE OF DEATH.

D10187

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Munsen ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Pearl

(Residence in Baltimore: No. 518 Munsen St.; 0 yrs., 0 mos. 0 ds.)

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 30 (Day), 1917. (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Cree Nicks

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Annie Pearl

13-BIRTHPLACE OF MOTHER (State or Country). Sussex County, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Pearl

(Address) 518 Munsen

15-

Filed ....., 191... ROBERT E. KRAUSE (Seal) Registrar.

DEC 1 - 1917 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 30 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 30 1917, to November 30 1917, that I saw her alive on November 30, 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Devalcourt M. D.

Nov. 30 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Nov. 3rd, 1917.

20-UNDERTAKER Charles B. Jones

ADDRESS 2350 Pennsylvania

Spec.—8-24-14—M. & T.—2000 Bks.

D10488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10483

REGISTERED NO. C.....

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 1534 Fesler ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie J Thomas

(Residence in Baltimore: No. 1534 Fesler St St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Oct 12 (Month) ..... (Day), 1887 (Year)

7-AGE, 30 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Banks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sophy Hall

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Rollins

(Address) 1539 Fesler St

15-

Filed DEC 1 1917, 191.. ROBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/19 1917, to 11/29 1917, that I saw h.. alive on 11/24 1917, and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

P. Tuberculosis Pulmonalis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) B. Lamb Robertson M. D.

11/29, 191.. (Address) 213 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion

DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER Edward Ring

ADDRESS 1463 N Gay

Spec.—8-24-14—M. & T.—2000 Bks.

D10489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10489

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kelly.

(Residence in Baltimore: No. Univ Hospt. St.; ...yrs., ...mos. 16ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1873 (Year)

7-AGE, 44 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Ship

9-BIRTHPLACE, (State or Country), Peru.

PARENTS.

10-NAME OF FATHER, Henry Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Jane Steinmetz.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paulin Bergman

(Address) 1110 Carroll St

15-

Filed ..... 191...

DEC 1 - 1917

ROBERT E. KRAUTH
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1917, to Nov 30 1917, that I saw him alive on Nov 30 1917, and that death occurred, on the date stated above, at 1.25 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Sclerosis

..... (Duration) Unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cystic & Mitral Insuff'y. (Duration) Unknown yrs. ... mos. ... ds.

(Signed) B. B. Brumbaugh M. D.

11-30., 1917. (Address) Univ. Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 16 ds. In the State Unknown yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Sparrows Point, Md.

19-PLACE OF BURIAL OR REMOVAL, 1st Ger Ev Church Lutz

DATE OF BURIAL, Dec 3, 1917.

20-UNDERTAKER Geo Lewin Locke Son

ADDRESS Corner Baker St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10490 HEALTH DEPARTMENT—CITY OF BALTIMORE D10490

CERTIFICATE OF DEATH.

REGISTERED No. C 47

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1907 W Fayette St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Glenn

(Residence in Baltimore: No. 1907 W Fayette St.: yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Aug (Month) 13 (Day), 1858 (Year)

7-AGE. 59 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telegrapher 086
(b) General nature of industry, business, or establishment in which employed (or employer): Western Union

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William R. Glenn

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Louise Simmerly

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Glenn

(Address) 1907 W Fayette St

15-

Filed DEC 1 1917, 191.... ROBERT B. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Embolism of Coronary Artery

(Duration) hrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic

(Duration) 3 yrs. mos. ds.

(Signed) James H Fenlon (Coroner) M. D.

Nov 29 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Dec 1 1917
UNDERTAKER	ADDRESS
Geo. A. Kerby	Balto & Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10491

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10491

1-PLACE OF DEATH

REGISTERED NO. C 91

CITY OF BALTIMORE (No. 1154 Cleveland St.; WARD 71)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. V. Creamer

(Residence in Baltimore: No. 1154 Cleveland St.; yrs. ; mos. ; ds.) Lifetime.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May 11, 1917 (Month) (Day) (Year)

7-AGE: yrs. 6 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Child 000
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Henry L Creamer

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Evelyn Seibert

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry A Creamer

(Address) 1154 Cleveland St

15-

ROBERT E. [illegible]
Burial Permit Clerk

Filed DEC 1 - 1917

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 29th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25th, 1917, to Nov 29th 1917, that I saw h[illegible] alive on Nov 29th, 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Empyema

From pleurisy that a mate (Duration) yrs. mos. ds

Contributory (SECONDARY) Pneumonia

History (Duration) yrs. 5 mos. ds.

(Signed) Henry Block M. D.

Dec 1, 1917 (Address) 1203 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Dec 1st, 1917

20-UNDERTAKER: Geo A Seibert

ADDRESS: Baltimore

D10492 HEALTH DEPARTMENT---CITY OF BALTIMORE D10492

CERTIFICATE OF DEATH

64

1 PLACE OF DEATH Johns Hopkins Hospital — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. North Broadway St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Julia Murray

(Residence in Baltimore: No. 1917 W. Lombard St.; 31 yrs. — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-~~SINGLE~~ MARRIED ~~WIDOWED OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: June 15 (Month) ..... 1865 (Year)

7-AGE: 52 yrs. 53 mos. ..... ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE (State or country): Charles Co Md

PARENTS

10-NAME OF FATHER: E L Hunt

11-BIRTHPLACE OF FATHER (State or country): Charles Co Md

12-MAIDEN NAME OF MOTHER: Mary A Murray

13-BIRTHPLACE OF MOTHER (State or country): Charles Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Geo L Murray

(Address): 1917 W Lombard St

15-DEC 1 1917 ROBERT R. KRAUTER. Filed ..... 191 ..... Burial Permit Clerk ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1917, to Nov 28 1917, that I saw h[er] alive on Nov 28 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.
Right hemiplegia first week in Sept. 1917
Cerebral hemorrhage causing left side symptoms and coma (Duration) 0 yrs 0 mos. 4 ds.

Contributory (SECONDARY): Bronchopneumonia (Duration) ..... yrs ..... mos. 4 ds.

(Signed) Augustus Scott M D

Nov 28, 1917 [Address] Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs — mos 13 ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 1917 W. Lombard St.

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Dec 3 1917

20-UNDERTAKER: Leo A Lerbig — ADDRESS: Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10493

HEALTH DEPARTMENT—CITY OF BALTIMORE

Schmitt

CERTIFICATE OF DEATH.

30 D10493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Dr. Ave. St.; 17 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Frank Schmidt.

(Residence in Baltimore: No. 800 Wilkens Ave. St.: 17 yrs., 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug. 4th, (Month) (Day) 1900 (Year)

7-AGE, 17 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Frank Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louise Hunzemuller

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Schmidt

(Address) 800 Wilkens Ave.

15-

Filed DEC 1-1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 30th 191 7, to Nov. 30th 191 7, that I saw h— alive on Nov. 29th 191 7, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis, Tuberculous

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Hiram Elliott M. D.

12/1/17, 191.., (Address) 92 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Dec 3, 191.7.

20-UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10494 HEALTH DEPARTMENT—CITY OF BALTIMORE D10494

156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 Lindsm ST.: 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Dorsch

(Residence in Baltimore: No. 1411 Lindsm St.; yrs., 36 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct. 12, 1881
(Month) (Day) (Year)

7-AGE, 36 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION: 071
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salvage Co. 630

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. D. Nash

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbra Doggett

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. D. Nash

(Address) 541 N. Broad

15-

Filed DEC 1 1917, 191.

ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Asphyxia
Accidental
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

191., (Address) 1728 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 12/3, 191.

20-UNDERTAKER Henry W. Meashey

ADDRESS 705 N. Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[redacted] D10495

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

[redacted] 120 D10495

REGISTERED No. C

CITY OF BALTIMORE (No. 527 Somerset St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hill

(Residence in Baltimore: No. 527 Somerset St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	col	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

3

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hill

(Address) 527 Somerset

15- DEC 2 - 1917 Filed ....., 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 27 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... (Coroner.) .....M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	Dec 2, 19 17
20-UNDERTAKER Ford R A Elliott	ADDRESS 5-06 East Pr

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10496

CERTIFICATE OF DEATH.

91 D10496

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 N. Bond St ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myra Shera Bradley

(Residence in Baltimore: No. 830 N Bond St St.; 7 yrs.. ..... mos. ..... ds.)

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—THE LETTERS AND FIGURES SHOULD BE PERFECT.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1845 (Year)

7-AGE,	If LESS than 1 day,
72 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) 1711 N. Bond St

15- DEC 2 - 1917 ROBERT B. KRAUTER

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 1st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1917, to Dec 1 1917, that I saw him alive on Dec 1 1917, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

..... Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec 1, 1917. (Address) 717 Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Royal	Dec ....., 191...
20-UNDERTAKER	**ADDRESS**
H W Lewis	140 E. 25th St

D10497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10497

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Silverman

(Residence in Baltimore: No. 519 S. Sharp St.: 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Unknown ....., 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
12 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Julius Silverman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rose Friedman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Silverman

(Address) 519 S. Sharp

15- Filed DEC 2 - 1917, 191.... ROBERT R. KRAUTER Registrar. Assistant Chief Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... November 30 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following internal injuries Caused by being run over by automobile (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Driscoll (Coroner.) M. D.

Dec 1, 1917 (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 519 S. Sharp St.

19-PLACE OF BURIAL OR REMOVAL, How Washington Rd | DATE OF BURIAL, Dec 2 1917

20-UNDERTAKER J. Lurman Bro | ADDRESS 1107 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10493

CERTIFICATE OF DEATH.

28

D10493

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 Aisquith ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline L. Conway

(Residence in Baltimore: No. 728 Aisquith St.; 37 yrs., mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, October (Month) 31st (Day), 1880 (Year)

7-AGE, 37 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Albert Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Braun

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Miller

(Address) 728 Aisquith St.

15- DEC 2 - 1917 ROBERT B. KRAUTER Registrar.

Filed....., 191.... Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15th 1917, to Nov 30th 1917, that I saw her alive on Nov 30 1917, and that death occurred, on the date stated above, at 6.55 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis
Following Typhoid Fever
Duration 3 mos.

CONTRIBUTORY (Secondary) Exhaustion ..... (Duration)..... yrs..... mos..... ds.

(Signed) E. M. C. Fuster M. D.

Dec 2nd, 1917. (Address) 111 W. Hoffman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	Dec 4, 1917
20-UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

USE INDELIBLE INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10499 D10499

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 W Henrietta ST.; 22 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hooper Green

(Residence in Baltimore: No. 502 W Henrietta St.; 42 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

213

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy Hicks

(Address) 502 W Henrietta

15-

Filed ....., 191.....

DEC 2-1917 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25 1917, to Nov 30 1917, that I saw h[im] alive on Nov 30, 1917, and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

(a) .....
(b) Septicemia
(c) .....
(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Arthritis Rheumatism (Duration) ..... yrs., ... mos. 3 ds.

(Signed) J. Gue Bowley M. D.

12/1/17, 191.. (Address) 136 W Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL. Dec 3, 1917

20-UNDERTAKER W S H Hooper ADDRESS 406 W Lanvale St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10500 D10500

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Rebecca St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Williams

(Residence in Baltimore: No. 706 Rebecca St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mail

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 24 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 044

9-BIRTHPLACE, (State or Country), Balt city

PARENTS.

10-NAME OF FATHER, Joash Williams

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER Mary Chase

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joash Williams

(Address) 706 Rebecca St

15-

Filed DEC 2 - 1917, 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 29 1917, that I saw him alive on Nov 29 1917, and that death occurred, on the date stated above, at 9 AM m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Anaemia

(Duration) ....yrs. ....mos. 7 ds.

(Signed) R. Hosea M. D.

Nov 29, 1917 (Address) 712 S. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemty — DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER Wm H Disque — ADDRESS 406 Monroe St

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10501 D10501

CERTIFICATE OF DEATH.

REGISTERED No. C 4120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 Hull ST. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Elloff.

(Residence in Baltimore: No. 1230 Hull St. St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct. 23, 1854 (Month) (Day) (Year)

7-AGE, 63 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H Elloff

(Address) 1230 Hull St.

15-

Filed DEC 2-1917, 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 191.7, to Nov. 30 191.7, that I saw h.r alive on Nov. 30 191.7, and that death occurred, on the date stated above, at 4 0. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (Duration) yrs. mos. ds.

(Signed) Philip C. Fowler M. D.

Dec. 1, 191.7 (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Freedom - Pa DATE OF BURIAL, Dec 4 191.7

20-UNDERTAKER Wm. Cook ADDRESS 502 E. Hull

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE WITH UNFADING INK

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10502 ✓ D10502

CERTIFICATE OF DEATH.

182

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2 - North - East Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy M. Newkirk

(Residence in Baltimore: No. 2 - North East Ave St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 4 (Day) 1884 (Year)

7-AGE 33 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home 000

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, James Swann

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Jennie Swan.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Swann

(Address) 910 Ramsay St

15- DEC 2 - 1917 ROBERT R. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 30, 191.. (Address) 4 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cal Lawn	Dec 3, 1917
20-UNDERTAKER Wm Cook	ADDRESS 502 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, Baltimore General Hospital

CITY OF BALTIMORE: (No. ..... ST.; 16 WARD)

REGISTERED NO. C 108 D10503

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ida Andrews

(Residence in Baltimore: No. Laurianda, Md. St.; 54 yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Nov. (Month) 23 (Day), 1863 (Year)

7-AGE, 54 yrs. ..... mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Philip Lambright

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Caroline Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Andrews

(Address) 4523 Parks Ave

15-

Filed ..... DEC 2- 1917 ....., 191..... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1917, to Nov. 27 1917, that I saw h er alive on Nov. 30 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Purulent appendicitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

..... (Duration) ..... yrs. 1 mos. 8 ds.

(Signed) Maurice E. Shaman M. D.

Nov. 30, 1917. (Address) 3300 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 54 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Laurinda Md

Former or usual residence 4523 Parks Ave Laurinda

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem. DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Wm Cook ADDRESS 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITING INK—THIS IS A PERMANENT RECORD

D10504

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D10504

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 154 N West St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Pearson

(Residence in Baltimore: No. 154 N. West

St.: 43 yrs. 6 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 13. (Month) 1874 (Day) (Year)

7 AGE: 43. yrs. 6 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 057

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Jones.

11 BIRTHPLACE OF FATHER (State or country): Norfolk V.a

12 MAIDEN NAME OF MOTHER: Anna Shanks

13 BIRTHPLACE OF MOTHER (State or country): Dorchester Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew J. Pearson

(Address) 219 Hanover St

15 Filed DEC 2. 1917 ROBERT P. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 30 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23rd, 1917, to Nov. 30th 1917, that I saw her alive on Nov. 30, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY): Paralysis of right side.

(Duration) ..... yrs. mos. 2 ds.

(Signed) Jennie R. Byrne M. D.

Dec. 1st, 1917. (Address) 510 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem. DATE OF BURIAL: Dec 3, 1917

20 UNDERTAKER: William Cook ADDRESS: 502 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10505

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10505

1-PLACE OF DEATH — REGISTERED NO. C 79

CITY OF BALTIMORE (No. 347 Yale Ave St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick H. Hettrich

(Residence in Baltimore: No. 347 Yale Ave St.: 35 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Oct 10, 1858 (Month) (Day) (Year)

7-AGE: 59 yrs. 1 mos. 20 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Photopher
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Frederick Hettrich

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Henriella Cron

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christina Hettrich

(Address) 347 Yale Ave

15-Filed DEC 2 - 1917, 191 ROBERT R. KRAUTER (REGISTRAR)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 1, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 15, 1917, to Nov 20 1917, that I saw h~~im~~ alive on Nov 19, 1917, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY): Arterial Sclerosis

(Duration) yrs. mos. ds.

(Signed) Howard W. Jones M. D.

Nov 30, 1917. (Address) Isabella

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: 12-3, 1917

20-UNDERTAKER: John Bell — ADDRESS: 28 Poppleton St

Spec.—8-24-14—M. & T.—2000 Bks.

D10506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10506

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 Ramsey ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Allen

(Residence in Baltimore: No. 1835 Ramsey St.)

Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Feb (Month) 9 (Day), 1869 (Year)

7-AGE. 48 yrs. 9 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country). Henry Clay Bowen

PARENTS.

10-NAME OF FATHER. Baltimore

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary C. Thomas

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter R. Allen Jr.

(Address) 1835 Ramsey

15- Filed DEC 2 - 1917 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1917, to Dec 1 1917, that I saw her alive on Dec 1 1917, and that death occurred, on the date stated above, at 9:25 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Endocarditis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 2 yrs. 2 mos. ds.

(Signed) Howard K. Taylor M. D.

Dec 2 1917 (Address) 2249 Wilkens

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet DATE OF BURIAL. Dec 4 1917

20-UNDERTAKER William Cook ADDRESS 507 E Nath

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

176 D10507

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 E. Preston ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Conn

(Residence in Baltimore: No. 802 E. Preston St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, November (Month) 6 (Day), 1844 (Year)

7-AGE, 73 yrs. ..... mos. 24 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 045
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country), Baltimore County

PARENTS.

10-NAME OF FATHER, Martin Conn

11-BIRTHPLACE OF FATHER (State or Country), Baltimore County

12-MAIDEN NAME OF MOTHER Martha Merryman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Austin B. Conn

(Address) 802 E. Preston St

15- DEC 2 - 1917 Filed ....., 191.... ROBERT R. KRAUSE Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Nov. 30 1917, that I saw him alive on Nov. 30 - 1917, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Prostatic infection, Cystitis,
Hypertrophied Prostate

(Duration) 1 yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Septic infection

(Duration) ..... yrs. ..... mos. 30 ds.

(Signed) Irving Miller M. D.

Nov. 30, 1917. (Address) 108 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery | DATE OF BURIAL, Dec. 3, 1917

20-UNDERTAKER John B. Spence | ADDRESS 1325 N. Carlton St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-17—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10508

CERTIFICATE OF DEATH.

64 D10508

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 D.N. ave. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Smith.

(Residence in Baltimore: No. 945 D. N. ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day) 1850 (Year)

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Domestic 877

(b) General nature of Industry, business, or establishment in which employed (or employer) 090

9-BIRTHPLACE, (State or Country). Balto., Md

PARENTS:

10-NAME OF FATHER, Rob. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Dunn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Smith

(Address) 1238 Division

15- Filed DEC 2 - 1917 191 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27th (Month) (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1917. to Nov. 27th 1917. that I saw h— alive on Nov. 27th 1917. and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. 2 mos. ds.

(Signed) A. Lee Ellis M. D.

Nov. 29, 1917 (Address) 22 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Cem. DATE OF BURIAL, Dec 2, 1917

20-UNDERTAKER Samuel T. Kennedy ADDRESS 578 W. Pratt St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Misc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10503

CERTIFICATE OF DEATH.

D

1-PLACE OF DEATH Kelley Son

CITY OF BALTIMORE: (No. 148 Eutaw Place St., 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Millie Barrick.

(Residence in Baltimore: No. 1418 Eutaw Place St.; 22 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE WITH UNFADING INK

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug (Month) 2 (Day) 1893 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. 4 mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
X (b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, David Clayton

11-BIRTHPLACE OF FATHER (State or Country), W Va

12-MAIDEN NAME OF MOTHER Nancy Lawson

13-BIRTHPLACE OF MOTHER (State or Country), W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H G Barrick

(Address) Pennsboro Va

15-

Filed DEC 3 • 1917, 191.....

ROBERT R. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 2 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Dec 2 1917, that I saw h[er] alive on Dec 2 1917, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Glycosuria Infection and
Intestinal Atony a
Post operative Shock

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Kidney Stones

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Elizabeth M. Morgan M. D.

Dec. 2, 1917 (Address) 1418 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State ..... yrs. ..... mos. 9 ds.

Where was disease contracted, if not at place of death? Pennsboro W. Va

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pennsboro W Va	Dec. 2, 1917.
20-UNDERTAKER C C Frame	ADDRESS 802 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

D10510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10510

CERTIFICATE OF DEATH.

REGISTERED NO. C 5-28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 Sterling ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Nicholas

(Residence in Baltimore: No. 673 Sterling St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Sept 21, 1898
(Month) (Day) (Year)

7-AGE. 19 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thomas Nicholas

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Marie Amos

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Nicholas

(Address) 673 Sterling St

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1917, to Dec. 1, 1917, that I saw him alive on Nov. 30, 1917, and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. 5 mos. ds.

(Signed) [illegible] M. D.

12/2 1917. (Address) 1520 Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 4, 1917

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

USE INDELIBLE INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10511

CERTIFICATE OF DEATH.

91 D10517

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Burgundy ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Potts

(Residence in Baltimore: No. 826 Burgundy St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	single

6-DATE OF BIRTH, Aug. (Month) 24 (Day), 1914 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 3 mos. 7 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Potts

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Potts

(Address) 826 Burgundy

15-

Filed DEC 3 1917, 191.... ROBERT P. KRAUTER Clerk
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 2 1917, that I saw h[illegible] alive on Dec 2 1917, and that death occurred, on the date stated above, at 3A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Martyn Craig M. D.

Dec 3, 1917. (Address) 727 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Dec. 3, 1917.

20-UNDERTAKER J. W. & J. E. Evans & Sons ADDRESS 1428 Bloadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

5 (One)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B10512 B10512

CERTIFICATE OF DEATH.

REGISTERED No. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 W Belmont av. St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Nicholas Erlbeck

(Residence in Baltimore: No. 27 W Belmont av St.; ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH PEN AND INDELIBLE INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 20, 1914
(Month) (Day) (Year)

7-AGE, 2 yrs. 11 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Erlbeck

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Dora Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Erlbeck

(Address) 27 W. Belmont

15-

Filed DEC 3 1917, 191...

ROBERT R. ... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1917, to Dec. 2, 1917, that I saw him alive on Dec. 1, 1917, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Spasmodic Croup

(Duration) ..... yrs. ..... mos. 36 ds.

CONTRIBUTORY (Secondary) 000

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene F. Cheshire M. D.

Dec. 2, 1917 (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Dec. 3, 1917

20-UNDERTAKER Wendell Dypsbee

ADDRESS 328 N ...

S (Over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10513

CERTIFICATE OF DEATH.

D10513

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1407 Stafford ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dempsey

(Residence in Baltimore: No. 1407 Stafford Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 4, 1857
(Month) (Day) (Year)

7-AGE, 67 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... — 000

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER. Wm Dempsey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine McCarty

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Dempsey

(Address) 1407 Stafford Ave

15-

Filed DEC 3 1917, 191.... ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1917, to Nov 25 1917, that I saw h.. alive on Nov 25 1917, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. E. Brumbach M. D.

Dec 3 1917 (Address) 1327 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery — DATE OF BURIAL, Dec 3.. 191...

20-UNDERTAKER Robt J Turner — ADDRESS 1424 Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10514

CERTIFICATE OF DEATH.

151 D10514

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 E. Lombard ST.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Oakes

(Residence in Baltimore: No. 3100 E. Lombard St.; ....yrs. ....mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Dec. 1st (Month) (Day), 1917 (Year)

7-AGE, ...yrs.....mos.....ds.

If LESS than 1 day, 4 hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Oakes

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Katherine Stergemeier

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George G. Oakes

(Address) 3100 E. Lombard St.

15-

Filed DEC 3 1917 191.... ROBERT R. KRAUTH Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191..., to Dec 1 191..., that I saw h... alive on ... 191..., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilat.

(Duration) ....yrs. 7 days mos. ....ds.

CONTRIBUTORY (Secondary) none

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Herrmann M. D.

Dec. 1 191... (Address) 2311 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Jno A. Inman

ADDRESS 3000 E. Balto St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE ONLY WITH UNFADING INK

D10515

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10515

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

Registered No. C 15

CITY OF BALTIMORE (No. 1711 Edmonson Ave — S — 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William B. Boyd

(Residence in Baltimore: No. 1711 Edmonson Ave. Sts. 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower.

6 DATE OF BIRTH: December (Month) 13 (Day), 1835 (Year)

7 AGE: 81 yrs. 11 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer. 014
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9 BIRTHPLACE (State or country): Montgomery Co. Md.

PARENTS

10 NAME OF FATHER: Thomas S. W. Boyd.

11 BIRTHPLACE OF FATHER (State or country): Scotland.

12 MAIDEN NAME OF MOTHER: Charlotte E. Frazier

13 BIRTHPLACE OF MOTHER (State or country): Scotland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Boyd
(Address) 1711 Edmondson Ave

15 Filed DEC 3 - 1917, 191 ROBERT R. KRAUTER Clerk of Burial Permits
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 1 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1917, to Dec 1, 1917, that I saw him alive on Dec 1, 1917, and that death occurred, on the date stated above, at 8:45 A m.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) — yrs. — mos. — ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W. L. Ingram M. D.
Dec 2, 1917 (Address) 2439 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 DATE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL: Dec 5, 1917

20 UNDERTAKER: Joseph B Cook ADDRESS: 1003 N Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10516

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 602 Monroe St.: 20 WARD)

REGISTERED No. C 40 D10516

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Roche

(Residence in Baltimore: No. 602 Monroe St.: 59 yrs. 4 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: July 10, 1808 (Month) (Day) (Year)

7-AGE: 59 yrs. 4 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home 037

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Lawrence Zinkand

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary Ann Schwenger

13-BIRTHPLACE OF MOTHER (State or country): Hagerstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gilbert Roche

(Address) 602 Monroe

15.

Filed DEC 3 - 1917 ROBERT R. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 29, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1917, to Nov 29 1917

that I saw her alive on Nov 29, 1917

and that death occurred, on the date stated above, at 9.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Primary (Duration) ..... yrs. ..... mos. ..... ds Unknown

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley A Cook M. D.

11-30, 1917 (Address) 541 Hilton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Dec 3, 1917

20-UNDERTAKER: Joseph B Cook — ADDRESS: 1013 N Gilmor St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10517

CERTIFICATE OF DEATH.

50 D10517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 S. Fulton ave ST.; 19 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Hodges

(Residence in Baltimore: No. 39 S. Fulton Av St.; 70 yrs., 7 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, April (Month) 3 (Day), 1847 (Year)

7-AGE, 70 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, John F. Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Sarah Collins

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.... ROBERT B. KRAUTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1. 1917, to Nov. 29. 1917, that I saw her alive on Nov. 29. 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(Duration) ...yrs. 6 mos. ...ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) ...yrs. mos. 1 ds.

(Signed) T. H. Wilson M. D.

11. 30., 191 7. (Address) 1735 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Dec 3rd, 191 7

20-UNDERTAKER Case & Co ADDRESS 1003 W Balto St

DEC 3 1917 BURIAL PERMIT Clerk

D10518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10518

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 828 Laborg. ST.: 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Goins

(Residence in Baltimore: No. 828 Laborg. St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

877

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Henry

(Address) 828 Laborg St.

15-

Filed DEC 3 - 1917 ROBERT E. KRAUTH Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) W. L. Driscoll M. D.
(Coroner.)

Dec 7, 1917. (Address) 121 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Brown & Richardson

ADDRESS 1149 E. Baltimore St

Spec.—8-24-14—M. & T.—2000 Blks.

D10519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10519

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Warren ST.; 21 WARD) REGISTERED NO. C.....

2-FULL NAME Charles Harrison Watts

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 905 Warren St.; ....yrs.,....mos.,....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Walter Watts

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Nettie Kell

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Kell

(Address) 905 Warren St

15- DEC 3 1917 ROBERT R. KRAUTER Registrar.

Filed ..... 191.. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Nov 29 1917, that I saw h[illegible] alive on Nov 29 1917, and that death occurred, on the date stated above, at 9.40 p.m.

The CAUSE OF DEATH* was as follows:

(Pneumonia Lobar

.....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ....yrs. ....mos. 7 ds.

(Signed) C. H. Owens M. D.

Nov 29, 1917. (Address) 712 S. Chas. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mont Auburn	Dec 3, 191.7
20-UNDERTAKER John H Owens	ADDRESS 533 Dolphin St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D10520

D10520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry H. Finch

(Residence in Baltimore: No. 215 St. Paul St. St.; ....yrs., mos. ds.)

N. B.—THIS IS A PERMANENT RECORD, AND WRITING IN INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 6, 1853
(Month) (Day) (Year)

7-AGE, 54 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 066

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. Finch

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Lee

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Edward

(Address)..... Mercy Hosp.

15-

Filed DEC 3 1917 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 191.., to Dec 2 191..,
that I saw h.. alive on Dec 2 191..,
and that death occurred, on the date stated above, at 2.50 m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Chronic Nephritis
Final Coma
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Cerebral Sclerosis, Chronic Endocarditis
(Duration) ....yrs. 6 mos. ....ds.
(Signed) Edward H. Smith M. D.
Dec 2, 191.. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 215 St Paul St

Former or usual residence 215 St Paul St

19-PLACE OF BURIAL OR REMOVAL, Greenlawn Cem. DATE OF BURIAL, Dec 4, 191.7

20-UNDERTAKER Stewart Memorial Co ADDRESS 108 W Mt Royal Av

Spec.—8-24-14—M. & T.—2000 Blks.

D10521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10521

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ulysses Gladstone

(Residence in Baltimore: No. 844 N Lombard St St.; 11 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD—USE INDELIBLE INK

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH, ..., 1863.
(Month) (Day) (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: factory work
(b) General nature of Industry, business, or establishment in which employed (or employer): 086

463

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Meade

(Address) Univ. Hosp.

15- DEC 3 - 1917 Filed ....., 191.... ROBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 1 1917, that I saw h[illegible]talive on Dec 1 1917, and that death occurred, on the date stated above, at 11.0 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 1 d. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 2, 1917. (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death? 844 N Lombard St

Former or usual residence 844 N Lombard St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, Dec 3, 191.

20-UNDERTAKER H. Krieger & Bro

ADDRESS 1107 E Balto St

D10522 HEALTH DEPARTMENT—CITY OF BALTIMORE D10522

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 16 N. Fremont Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman B. Eckmyer Jr

(Residence in Baltimore: No. 16 N. Fremont Ave. St.: yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, August 1, 1917
(Month) (Day) (Year)

7-AGE, 4 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Herman B Eckmyer Sr

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Margaret M. Smyth

13-BIRTHPLACE OF MOTHER (State or Country), Ohio.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Eckmyer

(Address) 16 N. Fremont

15-

Filed DEC 3 - 1917, 191.. ROBERT R. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Driscoll M. D.
(Coroner.)

Dec 7, 191.. (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec. 3, 1917

20-UNDERTAKER Mr Mrs John W Lemp

ADDRESS 801 W. Fayette St

Spec.—8-24-14—M. C.—2000 lbs.

D10523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Milton Ave ST.; 1 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Kistner

(Residence in Baltimore: No. 715 S. Milton Ave St.; 45 yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept (Month) 1st (Day), 1872 (Year)

7-AGE, 45 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver 023
(b) General nature of industry, business, or establishment in which employed (or employer): Oyster house

9-BIRTHPLACE, (State or Country), Balto City Md

PARENTS.

10-NAME OF FATHER, David Kistner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katie Seifert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilhelmina Kistner

(Address) 715 S. Milton Ave

15- DEC 3 - 1917

Filed....., 191.. ROBERT R. ... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-5- 1917, to 11-24- 1917, that I saw h[illegible] alive on 11-24-17 1917, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

[illegible] Conclusion

Dr. Smith (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleuro Pneumonia

(Duration) 2 yrs. mos. ds.

(Signed) J. A. Miller M. D.

11/30/17, 191.. (Address) 2139 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
[illegible] Evangelical Cem	Dec 3, 1917

20-UNDERTAKER	ADDRESS
H. Sander Sons	1711 East [illegible]

Spec.—8-24-14—M. & T.—2000 Ilks.

D10521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10521

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 377 S Gelmore ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Geisel

(Residence in Baltimore: No. 1378 Gelmore St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept 8 (Month) (Day), 1847 (Year)

7-AGE, 69 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Conrad Ruhr

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Lora Ruhr

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary E. Colvin

(Address) 378 S Gelmore

15- Filed DEC 3 - 1917, 191. ROBERT R. MAUTER Burial Permit Clerk & Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 16 1911, to Nov 30 1917, that I saw h[er] alive on Nov 30 1917, and that death occurred, on the date stated above, at 1 20 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, left nose

Chronic Nephritis 5

(Duration) 6 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(Duration) yrs. 5 mos. ds.

(Signed) F E Kunkel M. D.

Nov 30, 191. (Address) 1702 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Dec 3, 191.7

20-UNDERTAKER J Herwig & Co — ADDRESS 2008 Mcans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10525 HEALTH DEPARTMENT—CITY OF BALTIMORE D10525

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N Bruce ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Willing

(Residence in Baltimore: No. 428 N. Bruce St. St.; ..... yrs., ... mos. ..... ds.)

N. B.—THIS IS A PERMANENT RECORD, AND WRITING MUST BE IN INDELIBLE INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 22, 1845 (Month) (Day) (Year)

7-AGE, 72 yrs. 8 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Draftsman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

761

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ludwig Willing

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Willing

(Address) .....

15-

Filed DEC 3 1917, 191... ROBERT R. KRAUTH Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 10 1917, to Dec. 2 1917, that I saw h[illegible] alive on Dec. 1, 1917, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Intestine

.....

.....

..... (Duration) ... yrs. 12 mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) ... yrs. 5? mos. ... ds.

(Signed) J M Dellett M. D.

Dec. 2, 1917. (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 4th., 191.7

20-UNDERTAKER C. H. McCormick — 1931 W

ADDRESS Fayette st

Spec.—8-24-14—M. & T.—2000 Bks.

D10526 HEALTH DEPARTMENT—CITY OF BALTIMORE D10526

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Neal

(Residence in Baltimore: No. 2311 Mc Elderry St ST.; 1 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1895.
(Month) (Day) (Year)

7-AGE, 22 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Pass. Steel Plant 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bank Neal

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Manda Bristoll

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Graines

(Address) 2311 Mc Elderry St

15-

Filed ....., 191.... Registrar.

DEC 3 - 1917
ROBERT R. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Nov 30 1917, that I saw him alive on Nov 30 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Adolph L. Eisenberg M. D.

Nov 30, 1917. (Address) 2301 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary. Co. Md. DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Milton Lans ADDRESS 413 N Eden St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D10527

D10527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. OR (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Gatch

(Residence in Baltimore: No. 514 N. Arlington Ave. St.; 81 yrs. 11 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 15" 1835
(Month) (Day) (Year)

7-AGE, 81 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired 007
(b) General nature of industry, business, or establishment in which employed (or employer) Book Keeper

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Conduce Gatch

11-BIRTHPLACE OF FATHER (State or Country), Balto Co. Md.

12-MAIDEN NAME OF MOTHER Jane R. Rowland

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian E. Gatch

(Address) 514 N. Arlington Ave

15-

Filed DEC 3 1917 191.. ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3rd, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17th 1917, to Dec 3rd 1917, that I saw h[im] alive on Dec 3rd 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis arteriosclerosis.

(Duration) 5 yrs. mos. ds.

(Signed) C. C. Childs M. D.

, 191... (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 514 N. Arlington Ave.

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Dec 5", 191..

20-UNDERTAKER Joseph B Cook ADDRESS 1003 W. Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

966

8

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10528 105 D10528

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3I23 Dillon St. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Irene Schirmer

(Residence in Baltimore: No. 3I23 Dillon St. St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, September (Month) 7 (Day) 1892 (Year)

7-AGE,	If LESS than 1 day,
25 yrs. 2 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book-keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 008

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles L. Schirmer

11-BIRTHPLACE OF FATHER (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER Louisa C. Green

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles L. Schirmer

(Address) 3I23 Dillon St.

15-

Filed....., 191 Burial Permit Clerk

DEC 3 - 1917 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th 1917, to Dec. 1st 1917, that I saw her alive on Dec 1st 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) acute Indigestion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) David W. Jones M. D.

Dec. 3rd, 1917. (Address) 1013 N. Ellwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oaklawn Cemetery

DATE OF BURIAL, Dec. 4, 1917

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

D10529

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10529

CERTIFICATE OF DEATH

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1116 Hollins ST.: 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Taylor

(Residence in Baltimore: No. 1116 Hollins St.: 30 yrs. 0 mos. 0 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 [redacted] MARRIED WIDOWED OR DIVORCED (If rite the word): Married

6 DATE OF BIRTH: Nov. 12, 1853 (Month) (Day) (Year)

7 AGE: 64 yrs. 2 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Produce 045
(b) General nature of industry, business, or establishment in which employed (or employer): dealer

9 BIRTHPLACE (State or country): Falls Co. Tex.

PARENTS

10 NAME OF FATHER: Henry C. Rice

11 BIRTHPLACE OF FATHER (State or country): Tex.

12 MAIDEN NAME OF MOTHER: Charlotte Poor

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jno Chapman

(Address) 1116 Hollins

15

Filed DEC 3 1917 191 ROBERT B. KRAUTER

Burial Permit [redacted]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 1st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1916, to Nov. 30 1917,

that I saw h[illegible] alive on Nov. 30, 1917,

and that death occurred, on the date stated above, at 2-30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Hypostatic

(Duration) 2 yrs. 0 mos. 0 ds

Contributory (SECONDARY) Cardiac dilatation

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) C. B. Thorne M. D.

12/1, 1917 (Address) 1007 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Dec 3 1917

20 UNDERTAKER: Geo A Yerbey

ADDRESS: Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10530

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 N Broadford St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie E Jamart

(Residence in Baltimore: No. 802 N Broadford St.: ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Nov (Month) Brown (Day), 1 (Year)

7-AGE, 23 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Lemke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Alberta Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS GIVEN TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Jamart

(Address) Oxford Md.

15. DEC 3 - 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 2 1917, that I saw her alive on Dec 2 1917, and that death occurred, on the date stated above, at 1230P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Emil Novotny M. D.

Dec 3, 1917. (Address) 26 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oxford Md — DATE OF BURIAL, Dec 3, 1917.

20-UNDERTAKER Frank Enach & Son — ADDRESS 1906 E Lombard

5

Spec.—8-24-14—M. & T.—2000 Bks.

D10537 ✓ D10537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Jefferson St.; 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roscoe C. Dixon

(Residence in Baltimore: No. 1615 Jefferson St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Col.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Single

6-DATE OF BIRTH, Dec 15, 1917 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Gilbert Dixon

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER Violet Dockins

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Violet Dockins

(Address) 1629 Druid Hill Ave

15-

Filed ....., 191.... ROBERT B. HEALTH Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2 1917, to ..... 191...., that I saw him alive on Dec. 7 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(Duration) 1 hour yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Davis M. D.

Dec 7, 1917 (Address) 426 N. Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Dec 3..., 1917

20-UNDERTAKER Chas T. Johnson

ADDRESS 467 Caroline St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10532

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10532

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Chapel ST.: W WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton Karaban

(Residence in Baltimore: No. 509 S. Chapel St.; 23 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 3 (Day), 1894 (Year)

7-AGE, 40 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, Wenciesz Karaban

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Ludwika Jachimiak

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maryanna Karaban

(Address) 509 S. Chapel

15-

Filed DEC 3 - 1917, 191.....

ROBERT R. KRAUTER, Clerk, Burial Permit Division

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 27 1917, to December 1 1917, that I saw him alive on December 1 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Acute Bronchitis

..... (Duration) .....yrs. 1 mos. .....ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) .....yrs. .....mos. 14 ds.

(Signed) H. Simmons M. D.

....., 191.7. (Address) 222 S. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus	Dec. 5, 1917.
20-UNDERTAKER	**ADDRESS**
Stephen J. Trakowski	1019 S. Kenwood Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10533

CERTIFICATE OF DEATH.

120 D10533

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Kraft

(Residence in Baltimore: No. 154 Landwehrs Lane St.; 40 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 30 (Day), 1847 (Year)

7-AGE, 70 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Ulsaker

(Address) 20 S. Mount St

15-

Filed DEC 3 - 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 3d (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1917, to Dec 2d 1917, that I saw h.. alive on Dec 2nd 1917, and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Senility, Heart failure

Contributory (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

Contributory (Duration) yrs. mos. ds.

(Signed) H. S. Mitchell M. D.

Dec 3d, 191 7. (Address) H. S. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 154 Landwehrs Lane

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Dec 6th, 191 7.

20-UNDERTAKER F. D. Fleischmann

ADDRESS 2236 Eutaw Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10531

CERTIFICATE OF DEATH.

78 D10531

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Jenkins.

(Residence in Baltimore: No. 425 E. North Ave ST.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. Dec 11, 1862
(Month) (Day) (Year)

7-AGE. 54 yrs. 11 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nurse-maid
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Daniel Keenan

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Bridget Horgan

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. C. Jenkins

(Address) 425 E. North Ave.

15-

Filed DEC 3 - 1917, 191.... ROBERT R. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1917, to Dec 1 1917, that I saw her alive on Nov 30 1917, and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(Duration) yrs. 2 mos. ds.

(Signed) Ernest T. McKeen M. D.

Dec. 1, 1917. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. 1 mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 425 E North Ave

Former or usual residence 425 E North Ave.

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL, Dec 3, 1917

20-UNDERTAKER Reed & Ward Co. ADDRESS 1811 N. Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10535

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10535

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE (No. 2517 Maryland Ave. STR. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Mehlgarten

(Residence in Baltimore: No. 2517 Maryland Ave. St.; 70 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June 22, 1843 (Month) (Day) (Year)

7-AGE: 74 yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman of 066
(b) General nature of industry, business, or establishment in which employed (or employer): Willow Ware 066

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: August Mehlgarten

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth Greine

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alvina Mehlgarten

(Address) 2517 Maryland Ave

15 DEC 3 - 1917 Filed ....., 191.... ROBERT R. KRAUTEL Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 1st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 191.., to Dec 1 191..,
that I saw h.. alive on Dec 1st, 191.., and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) August Horn M. D.

Dec 3rd, 191.. (Address) 2517 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine

DATE OF BURIAL: Dec 4 .191 7

20-UNDERTAKER: Geo W Little

ADDRESS: 531 N Fremont Ave

8

D10536

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D10536

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1227 Wall St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W.Bachmann.

(Residence in Baltimore: No. 1227 Wall St.

St.; 45 yrs., 4 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH. July 11th. 1872., 1..... (Month) (Day) (Year)

7-AGE. 45 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pressman in
(b) General nature of industry, business, or establishment in which employed (or employer): Enameling and Stamping works.

063

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles W.Bachmann.

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Elizabeth.-------

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha Bachmann. (wife)

(Address) 1227 Wall St.

15- DEC 3 - 1917

Filed....., 191.....

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1st. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Geo. M. Reinhardt M. D.

(Coroner)

Dec, 1st. 17. 1017 S.Charles St

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cemetery	Dec. 4th, 1917.
20-UNDERTAKER	**ADDRESS**
Fred. A Krause	703 Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

219

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10537

28 ✓ D10537

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Aisquith ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McCormick

(Residence in Baltimore: No. 1034 Aisquith St.; 5 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 2, 1853
(Month) (Day) (Year)

7-AGE, 64 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Florist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Samuel McCormick

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Winifred Dalton

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. McCormick

(Address) 1034 Aisquith St

15-

Filed DEC 3 - 1917, 191.....

ROBERT P. FRAILEY
Registrar.

Dr Devine on

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 191 7, to December 1 191 7, that I saw h ii alive on Nov 30 191 7, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. 11 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos J. Flynn M. D.

Dec 2, 191 7 (Address) 2411 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Cathedral Cem — DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER H. C. Wedefeld — ADDRESS 9 & Gramm Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10538

CERTIFICATE OF DEATH.

D10538

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Car Hamms & Patterson Pk ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Stolzenbach

(Residence in Baltimore: No. 818 E Patterson Pk St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 4 (Month) 6 (Day) 1857 (Year)

7-AGE, 60 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Clothing 080 (b) General nature of industry, business, or establishment in which employed (or employer), worker

9-BIRTHPLACE. (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo Stolzenbach

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Wimert

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Butler

(Address) 426 Patterson

15- Filed DEC 3 - 1917, 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. R. Mantz M. D. (Coroner.)

Dec 4, 1917 (Address) 426 Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

8

Spec.—8-24-14—M. & T.—2000 Bks.

D10539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10539

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Castle ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Myers

(Residence in Baltimore: No. 217 S. Castle St.; 66 yrs., 5 mos. 23 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, June 7th, 1851 (Month) (Day) (Year)

7-AGE, 66 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 003
(b) General nature of industry, business, or establishment in which employed (or employer): Baker

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Unk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unk

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Kollinger

(Address) 217 S. Castle St.

15-

DEC 3 - 1917

Filed....., 191.....

ROBERT B. KRAUTER

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1917, to Dec 1 1917, that I saw h[illegible] alive on ....., 191..., and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

1. Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(Duration) 7 yrs. 3 mos. ds.

(Signed) Geo. L. Wilkins M. D.

Dec 3, 1917. (Address) 6 E. Mt. Royal

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10540 D10540

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 S. Durham ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Betlyewski.

(Residence in Baltimore: No. 517 S. Durham St.; ....yrs., 11 mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Single.

6-DATE OF BIRTH, December 29, 1916.
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Joseph Betlyewski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Sophia Grlenske

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Betlyewski

(Address) 517 S. Durham St.

15-
Filed DEC 3 - 1917, 191.... ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1917, to Dec 2 1917, that I saw h in alive on Dec 2 1917, and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) ....yrs. ca 2 mos. ....ds.

(Signed) M. Jamieson M. D.

Dec 3, 1917. (Address) 2431 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
N. Stanislaus.	Dec 4, 1917.

20-UNDERTAKER W. F. Sadowski ADDRESS 905 S. Ann

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10511 D10512

1 PLACE OF DEATH

REGISTERED NO. C 92

CITY OF BALTIMORE: (No. 414 Gridall ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Robert Johnson

(Residence in Baltimore: No. 1414 Gridall St. 1 yrs. 11 mos. 20 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Single

6-DATE OF BIRTH December (Month) 12 (Day) 1915 (Year)

7-AGE 1 yrs. 11 mos. 20 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: not any good
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER George Johnson

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Mary Ann Gray

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Johnson

(Address) 414 Gridall St

15- DEC 3 - 1917 ROBERT R. KRAUTER

Filed ....., 191 ..... Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH December (Month) 2 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1917, to Dec 2nd 1917, that I saw h.im alive on Dec 2nd 1917, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pneumia

(Duration) 2 yrs ..... mos. 2 ds.

Contributory (SECONDARY) Lobar Pneumonia

(Duration) 2 yrs ..... mos. 3 ds.

(Signed) J. H. Buxton M. D.

Dec 2nd 1917 [Address] 301 E. Cross St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park

DATE OF BURIAL Dec. 4, 1917

20-UNDERTAKER E J Fanning

ADDRESS 1460 Bulling

D10542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

173 D10542

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1110 Brevard ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank S. Rowe

(Residence in Baltimore: No. 1110 Brevard St.: 8 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 16, 1909
(Month) (Day) (Year)

7-AGE, 8 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Glyndon Md

PARENTS.

10-NAME OF FATHER, R Rodolph Rowe

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Beulah L Duncan

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R Rodolph Rowe

(Address) 1110 Brevard St

15- DEC 3-1917 Filed....., 191.... ROBERT R. KRAUTER Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon und from the evidence obtained by said.....
(Iuquest, au-
.....find that said deceased came to.....death
topsy or inquiry.)
ou the day stated ubove.
The CAUSE OF DEATH* was as follows:

Fracture of Skull
by a fall from
Electric car (accident)
(Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secoudary)
(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)
Dec. 191.. (Address) 196 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Vault - Loudon Pk.	Dec. 4, 1917
20-UNDERTAKER William Cook	ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PENCIL, WITH ENGRAVING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10543 ✓ D10543

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Lee Allen

(Residence in Baltimore: No. 1628 E Clement St.: Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, October 31, 1876
(Month) (Day) (Year)

7-AGE 41 yrs. 1 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Andrew Seward

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Carrie Brown

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Allen

(Address) 1628 E. Clement St

15-

Filed....., 191.....

DEC 3-1917 ROBERT R. KRAUTER
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3rd, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13th 1917, to Dec. 3rd 1917, that I saw h[illegible] alive on Dec 2nd 1917, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency Arteriosclerosis

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pneumonia confluent

..... (Duration).....yrs.....mos. 20 ds.

(Signed) Ernest M. F. Burgess M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 20 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Dec 5, 1917

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10541 D10541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; WARD)

2-FULL NAME Wm Thomson

(Residence in Baltimore: No. Mercy Hospital St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Aug 23, 1881
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 3 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Day Work

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, John Thomson

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Eliza McKon

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record.

(Address) Mercy Hosp

15-

Filed DEC 3 - 1917, 191... ROBERT P. KRAUTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1917, to Nov. 30 1917, that I saw h[illegible] alive on Nov. 30 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

X (Duration) yrs. mos. ds.

(Signed) Edward D. Smith M. D.

Nov 30, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death? Curtis Bay Md.

Former or usual residence Curtis Bay Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, DEC 1 - 1917, 191...
JOHNS HOPKINS HOSPITAL Commissioner Health,	
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15382

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10545

D10545

51

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 N. Lexington St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Catherine Pohlmeier

(Residence in Baltimore: No. 1021 N. Lexington St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 21 (Day), 1865 (Year)

7-AGE, 52 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Lang

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Lauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Pohlmeier

(Address) 1021 N. Lexington

15-

Filed DEC 3 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Nov 30 1917, that I saw h[illegible] alive on Nov 30 1917, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Goiter,

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 14 ds.

(Signed) J. Walker Thomas M. D.

Dec 1st, 1917 (Address) 1238 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cemetery — DATE OF BURIAL, Dec 4th 1917.

20-UNDERTAKER Geo J. Smith — ADDRESS 1000 N. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D10516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D10516

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rocco Scoglione

(Residence in Baltimore: No. 653 W. Lexington St.: yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1896
(Month) (Day) (Year)

7-AGE, 21 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Huckster
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) University Hospital Record

(Address) Fayette & Lombard Sts

15- Filed DEC 3 - 1917, 191.....

ROBERT R. KRAUTER.
Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) 0 yrs. ..... mos. ..... ds.

(Signed) C. J. Driscoll M. D.
(Coroner.)

Dec 3 191.. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. 1 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents	Dec 5th 191..
20-UNDERTAKER Jno F Clay & Sons	ADDRESS 318 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10547

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D10547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Leadenhall ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Jordan

(Residence in Baltimore: No. 1911 Leadenhall St.: 27 yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day) ..... (Year)

7-AGE, 27 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Brown

(Address) 1011 Leadenhall St

15-

Filed DEC 4 1917 ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 2 1917, that I saw h[im] alive on Dec 2 1917, and that death occurred, on the date stated above, at 9.10a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) .....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) .....yrs.....mos. 6 ds.

(Signed) J. Guy Smith M. D.

12/2/17, 191.. (Address) 1514 W. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn St	Dec 4, 1917
20-UNDERTAKER	ADDRESS
S. E. Brown & Son	W. Pratt St

D10548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 ✓ D10548

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bush St. Dock. St: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clirton E.Murray.(C)

(Residence in Baltimore: No. 423 W.Hamburg St. St.: yrs. 13 mos. 7 ds. 7)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, April 7th. 1904. (Month) (Day) , 1 (Year)

7-AGE,	If LESS than 1 day,
13 yrs. 7 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Murray.(C)

11-BIRTHPLACE OF FATHER (State or Country) Calvert Co.Md.

12-MAIDEN NAME OF MOTHER Annie Brooks.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Murray.(C)mother.
(Address) 423 W.Hamburg St.

15-
Filed DEC 4 - 1917, 191 ROBERT R. [illegible]
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing Nov,14th.1917 Body found December 1st.1917; 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M Rennhardt (Coroner) M. D.

Dec,3rd. 191.7. (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, ..., 19...

20-UNDERTAKER C.H.Brown & Son | ADDRESS 1017 W.Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10519

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10519

CERTIFICATE OF DEATH

164

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Fleet St. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Belma Hesselbach

(Residence in Baltimore: No. 1929 Fleet St.; yrs. 2 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct (Month) 1st (Day), 1915 (Year)

7-AGE: — yrs. 2 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): City

PARENTS

10-NAME OF FATHER: Geo. Hesselbach

11-BIRTHPLACE OF FATHER (State or country): City

12-MAIDEN NAME OF MOTHER: Kate Hechmelt

13-BIRTHPLACE OF MOTHER (State or country): City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Geo Hesselbach

(Address) 1929 Fleet St

15- DIED - 1917 ROBERT R. KRAUTH Burial Permit Clerk

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December (Month) 3rd (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 31st, 1917, to, December 3rd 1917, that I saw her alive on December 3rd 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Exhaustion (Toxemia) (marasmus)

Indef. (Duration) yrs mos. ds.

Contributory (SECONDARY) Gastro-Enteritis (Bacill.)

Indef. (Duration) yrs mos. ds.

(Signed) J. albert miller M. D.

12-4- 1917 [Address] 2731 Eastern Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel

DATE OF BURIAL: Dec 5, 1917

20-UNDERTAKER: Peter Nicolaus

ADDRESS: 2046 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10550 ✓D10550

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 603 Carrell St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Hall

(Residence in Baltimore: No. 603 Carrell St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Letta Johnson

(Address) 603 Carrell

15-

DEC 4 - 1917

Filed ....., 191.... ROBERT B. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Driscoll M. D.
(Coroner.)

Dec 7, 191.. (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec. 4, 19 17
20-UNDERTAKER	ADDRESS
Samuel J. Hemsley	578 Biddle St

Spec.—8-24-14—M. & T.—2000 Bks.

D10551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10551

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 E. Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gussie Benoith

(Residence in Baltimore: No. 1135 E. Lombard St.; 24 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1833
(Month) (Day) (Year)

7-AGE, 84 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Baltimore St

15-

Filed DEC 4 - 1917 191 ROBERT R. KRAUTER
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1917, to Dec 3 1917, that I saw her alive on Dec 3 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Nathan J. Helfgott M. D.

Dec 3, 1917. (Address) 109 W. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herron Run

DATE OF BURIAL, 12/4, 1917.

20-UNDERTAKER Jack Levis

ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D10552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10552

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Bond St ST.; 3 WARD)

2-FULL NAME Sterne Kremer

(Residence in Baltimore: No. 15 S. Bond St St.; 4 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, August 8, 1870
(Month) (Day) (Year)

7-AGE, 47 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nirkam

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Nirkam

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St

15-

Filed DEC 4 - 1917, 191.....

ROBERT R. KEISTER
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1917, to Dec. 3 1917, that I saw her alive on Dec 3 1917, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Intestinal Complaint Pulmonary Tuberculosis,

(Duration) yrs. mos. ds.

(Signed) Wm J Gaynor M. D.

Dec 3, 1917. (Address) 212 Fairmount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 12/4..., 1917.

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

D10553

HEALTH DEPARTMENT---CITY OF BALTIMORE

D10553

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Registered No. C 10

CITY OF BALTIMORE: (No. 1437 Dawson St. 24 Ward)

2-FULL NAME Mary E Hamilton

(Residence in Baltimore: No. 1437 Dawson St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Sept 23 (Month) (Day) 1845 (Year)

7-AGE: 71 yrs. 2 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: John Keelan

11-BIRTHPLACE OF FATHER (State or country): Baltimore,

12-MAIDEN NAME OF MOTHER: Mary Keelan

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Franklin

(Address) 1437 Dawson St.

15-

Filed ..., 191 ... REGISTRAR

DEC 4 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 1 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1917, to Dec 1 1917, that I saw h[illegible] alive on Dec 1 1917, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Grippe Pneumonia

(Duration) — yrs. — mos. 2 ds.

Contributory (SECONDARY) Lobar pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) H. Leo Mundorff M. D.

Dec 4th, 1917 [Address] 1328 St Paul

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Md Sol Cem Co

DATE OF BURIAL: Dec 4 1917

20-UNDERTAKER: Mrs J. E. Evans Son

ADDRESS: 1428 St Paul

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10551

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 E Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harvey C. Baker

(Residence in Baltimore: No. 2125 E Federal St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 8, 1867
(Month) (Day) (Year)

7-AGE, 50 yrs. 9 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Horse Shoer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER John Baker

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Ellen Yingling

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Baker

(Address) 2125 E Federal st

15-

Filed....., 191.....

DEC 1 - 1917

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 1 1917, that I saw h[illegible] alive on Nov 30, 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Unknown) (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) M. F. Tyson M. D.

Dec 1/17, 191... (Address) 627 N. Montford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER Albert C Fuller ADDRESS 221 N Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5

Spec.—8-24-14—M. & T.—2000 Bks.

D10555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10555

CERTIFICATE OF DEATH.

REGISTERED NO. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 Whitridge Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Meyer

(Residence in Baltimore: No. 445 Whitridge Ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	W

6-DATE OF BIRTH, April 21 (Month) (Day), 1854 (Year)

7-AGE, 63 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Meyer

(Address) 445 Whitridge Ave

15- DEC 4 - 1917 ROBERT R. KRAUTER

Filed....., 191... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 1st (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 1917, to Dec 1 1917, that I saw h[er] alive on Nov 29 1917, and that death occurred, on the date stated above, at 4:40 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 20 ds.

(Signed) John L. Yellott M. D.

Dec 1, 1917. (Address) 1936 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	Dec 4, 1917
20-UNDERTAKER	**ADDRESS**
Christian Miller	2357 E. Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10556 HEALTH DEPARTMENT—CITY OF BALTIMORE 50 D10556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2499 Druid Hill Ave St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael H. Tooher

(Residence in Baltimore: No. 2499 Druid Hill Ave St.; 67 yrs. 9 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 5th, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael H. Tooher

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Tooher

(Address) 2499 Druid Hill Ave

15- Filed DEC 4 - 1917, 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12 1913, to Dec 2 1917, that I saw h.. alive on Dec 2 1917, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 4 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Nelson M. D.

Dec 3, 1917. (Address) 1311 North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Balto Cem — DATE OF BURIAL. Dec 5th, 191.7

20-UNDERTAKER W. M. Gauthier — ADDRESS 1624 Mt Royal ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S

D10557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10557

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 119 W. 21 St. St.; 17 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Augens

(Residence in Baltimore: No. 119 W. 21 St St.; yrs., mos. 2 /ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Dec (Month) 11 (Day) 1917 (Year)

7-AGE, ...yrs. .....mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... nn 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balt Co

PARENTS.

10-NAME OF FATHER Edward Augens

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Blanch Hall

13-BIRTHPLACE OF MOTHER (State or Country), Hayfordsville Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Augens

(Address) 119 W. 21 St

15- DEC 4 - 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) ....find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. Lee Mossman M. D.
(Coroner.)

Dec 4 1917 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lauel Cemetery

DATE OF BURIAL, Dec 6 1917

20-UNDERTAKER Geo Holland

ADDRESS 1631 Pinkney Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10558

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10558

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 McElderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Potts

(Residence in Baltimore: No. 1614 McElderry St.; ...yrs.,, mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~ Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... House work

9-BIRTHPLACE, (State or Country). St Marys Co Md

PARENTS.

10-NAME OF FATHER, Ignatious Toney

11-BIRTHPLACE OF FATHER (State or Country). St Marys Co Md

12-MAIDEN NAME OF MOTHER Ann Toney

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R A Elliott

(Address) 506 East St

15-

Filed DEC 4 - 1917, 191.....

ROBERT R. CARTER
Burial Permits Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2nd, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2 1917, to ..... 191..., that I saw her alive on Dec. 2 1917, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

Years Man'd

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ...yrs. 1 mos. ...ds.

(Signed) E. Allen Reed M. D.

12/3/17, 191.. (Address) 1425 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, Dec 5..., 191.7.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 East St

Spec.—8-24-14—M. & T.—2000 Blks.

D10559

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D10559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 E Hoffman St.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina L Hammerald

(Residence in Baltimore: No. 2407 E Hoffman St.; ....yrs.. ....mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH, July 27, 1893 (Month) (Day) (Year)

7-AGE, 24 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frederick Hammerald

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katie Metzgar

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie L Hammerald

(Address) 2407 E Hoffman

15- Filed DEC 4 - 1917, 191.... ROBERT P. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Dec 2 1917, that I saw her alive on Dec 2 1917, and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) 4 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. D. Maclaren M. D.

Dec 2, 1917. (Address) 1514 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dallas Country — DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER Robt J Turner — ADDRESS 144 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D10560 HEALTH DEPARTMENT—CITY OF BALTIMORE D10560

CERTIFICATE OF DEATH.

REGISTERED No. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Colvin ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William P. Davis

(Residence in Baltimore: No. 612 Colvin St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR ~~RACE~~. Col.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Aug (Month) 23 (Day) 1882, (Year)

7-AGE. 35 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)

65-13

9-BIRTHPLACE, (State or Country) Richmond Va

PARENTS.

10-NAME OF FATHER. Charles H Davis

11-BIRTHPLACE OF FATHER (State or Country). Richmond Va

12-MAIDEN NAME OF MOTHER Josephine Bowing

13-BIRTHPLACE OF MOTHER (State or Country). Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Davis

(Address) 449 E. 23rd Street

15-

Filed ..... 191.....

DEC 4 - 1917 ROBERT B. CHANEY BUREAU OF VITAL STATISTICS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. (Month) 30th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30th 1917, to Dec. 3rd 1917, that I saw him alive on Dec. 3rd 1917, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) X yrs. X mos. 1 ? da.

CONTRIBUTORY (Secondary) Hypostatic, Dropsy

(Duration) X yrs. X mos. da.

(Signed) Dr. Lucas E. Hall M. D.

Dec 4, 1917. (Address) 1425 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL, Dec. 6, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 E. 25th

Spec.—8-24-14—M. & T.—2000 Bks.

D10561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10561

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mt. Gen. Hosp. St.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Purdy

(Residence in Baltimore: No. Sparrows Point (Bled a St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, black.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 24 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Steel Company

(Address) S. P.

15-

Filed DEC 4 - 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1917, to Dec. 1 1917, that I saw h[illegible] alive on Dec 1- 1917, and that death occurred, on the date stated above, at 7P. m.

The CAUSE OF DEATH* was as follows:

Interstitial ulceration
Gastro-Enterostomy
from bowel (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis-general

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. Dolfus M. D.

Dec 1 -, 191?. (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Hampton - Va.

19-PLACE OF BURIAL OR REMOVAL, Hampton Va. DATE OF BURIAL, Dec. 4, 1917.

20-UNDERTAKER Wm Cook ADDRESS 502 E Holt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT, WHITE ENVELOPE, WHITE CARD.

5

V. 6036

D10562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10562

CERTIFICATE OF DEATH.

REGISTERED No. C 183

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Gaskins

(Residence in Baltimore: No. 607 N Vincent St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	Single

6-DATE OF BIRTH, Not known ....., 1883
(Month) (Day) (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): own home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Gaskins

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Roy

(Address) 1137 N. Carey St.

15-

Filed DEC 4 1917, 191

ROBERT B. KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Stab wound in her abdomen Severed the bowels Causing Peritonitis, Murder
(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septicaemia
(Duration) yrs. mos. 4 ds.

(Signed) James M Fenlon M. D.
(Coroner.)
Dec 4, 1917 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death Franklin Sq Hos In the yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? 507 N Vincent St

Former or usual residence 507 N Vincent St

BURIAL OR REMOVAL, [redacted] cemetery

UNDERTAKER James H. Dennis

DATE OF BURIAL, Dec 4 1917

ADDRESS 1303 Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10563

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

12a D10563

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Woodley) ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Doyle

(Residence in Baltimore: No. 903 Woodley Av St.; yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1859 (Year)

7-AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(h) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Wm F Doyle

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary A Monahan

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Barbara Doyle

(Address) 903 Woodley Av

15-

Filed ..... 191.....

DEC 4 - 1917 ROBERT R. KRAMER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 3 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1917, to, Dec 3 1917, that I saw h[illegible] alive on Dec 3 1917, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs 5 mos. ds.

Contributory (SECONDARY) Pneumonia

(Duration) yrs mos. 12 ds.

(Signed) James Boyd M. D.

Dec 4, 1917 [Address] 602 Columbia

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral DATE OF BURIAL: Dec 7, 1917

20-UNDERTAKER: Martin Fahey Sons ADDRESS: 66 Lafayette Av

D10564

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 D10564

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 306 S Garrison Ave ST.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno. L Lovering

(Residence in Baltimore: No. 306 S Garrison Ave St.: yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: 6 (Month) 2 (Day), 1916 (Year)

7-AGE: 1 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Jno L Lovering

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Anna M Watts

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jno Lovering

(Address) 306 Garrison Ave

15-

Filed DEC 4 - 1917, 191

ROBERT R. [illegible]
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 14 (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30, 191 . to. Dec 14 191 , that I saw h alive on Dec 3rd , 191 7, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) General Weakness

(Duration) yrs. mos. ds.

(Signed) Benj Lindsay M. D.

Dec 14, 1917 (Address) 400 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: at Pikes

DATE OF BURIAL: Dec 4th, 1917

20-UNDERTAKER: John J Fields

ADDRESS: 1200 N Lombard

Spec.—5-19-13—M. & T.—500 Bks.

D10565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10565

CERTIFICATE OF DEATH.

1090

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S Caey ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Martin

(Residence in Baltimore: No. 107 S Caey St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 9 (Day) 1914 (Year)

7-AGE, 3 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Walter Martin

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Catherin Tyrell

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Martin

(Address) 107 S Caey st

15-

Filed. DEC 4 1917, 191. ROBERT E. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 2 1917, that I saw him alive on Dec 2 1917, and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Collapse

(Duration) yrs. mos. ds.

(Signed) Joseph E. Miller M. D.

Dec 3, 1917. (Address) 1520 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Dec 6th 1917

20-UNDERTAKER John J. Reilly

ADDRESS 1200 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D10566 W CERTIFICATE OF DEATH. 91 D10566

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Calhoun St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Brown

(Residence in Baltimore: No. 1319½ Calhoun St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct. (Month) 9th (Day) 1917 (Year)

7-AGE, ...yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Servant
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, George Terry.

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brown

(Address) 1319½ Calhoun St.

15- Filed DEC 4 - 1917, 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 8th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/4 - 1917, to 12/8 1917, that I saw h... alive on 12/3 - 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(b) Influenza

(c)

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Bunting Carter M. D.

....., 191... (Address) 1139 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec 5th, 191...

20-UNDERTAKER Samuel E. Wright — ADDRESS 2364 Maryland

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10567

CERTIFICATE OF DEATH.

D10567

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Centrue ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Dr Causey

(Residence in Baltimore: No. 501 N. Centrue ave. St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
27 yrs. ....mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Asbury Howard

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Dr Causey

(Address) 501 N. Centrue ave.

15-

Filed ....., 191.....

Registrar.

DEC 4 - 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26, 1916, to Dec 1, 1917, that I saw h[er] alive on Dec 1, 1917, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert F. Krauter M. D.

Dec. 3, 1917. (Address) 120½ Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pine Grove Cem.	Dec. 5, 1917.

20-UNDERTAKER	ADDRESS
Wm J. G. Looks	1302 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10568

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10568

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bidder & Allerton Sanatorium St. 18 WARD)

REGISTERED No. C 170

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Kalbfleisch

(Residence in Baltimore: No. 422 N. Arlington Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: February (Month) 7 (Day), 1865 (Year)

7-AGE: 52 yrs. 9 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Chas. Nicholson

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Josephine Thomas

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Kalbfleisch

(Address) 422 N. Arlington Ave

15. Filed DEC 4 - 1917 191 ROBERT B. KRAUSER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 3rd (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1917, to Dec 3 191 ,
that I saw h..... alive on Dec 3rd, 1917,
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. 3 mos. ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 3rd, 191 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at 422 N. Arlington Ave

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 6 1917

20-UNDERTAKER: George J. Smith — ADDRESS: 100 W Fayette

Spec.—5-19-13—M. & T.—500 Bks.

D10569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10569

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 E Fayette ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Brown

(Residence in Baltimore: No. 1531 E. Fayette St St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widowed

6-DATE OF BIRTH, May 8, 1859
(Month) (Day) (Year)

7-AGE, 58 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Watson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Lee

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene Lynch

(Address) 1531 E. Fayette St.

15- DEC 4 - 1917 ROBERT R. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 191 7, to Dec 3 191 7, that I saw h M alive on Dec 1 191 7, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

1 Nephritis

Chronic Interstitial

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Richard L. Eccles M. D.

Dec 3, 1917 (Address) 1514 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery — DATE OF BURIAL, Dec 6, 1917

20-UNDERTAKER Milton Davis — ADDRESS 403 N Eden St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS CERTIFICATE, WITH ENDORSEMENTS, IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10570

REGISTERED No. C 29 D10570

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2508. Elsmore Ave ST. 15th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Martha Shoemaker

(Residence in Baltimore: No. 2508 Elsmore St.: 69 yrs. 7 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: April 13, 1848 (Month) (Day) (Year)

7-AGE: 69 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Dorchester Co. Md

PARENTS

10-NAME OF FATHER: Robert Marshall

11-BIRTHPLACE OF FATHER (State or country): Dorchester Co Md

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER (State or country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa M Henderson (Daughter)

(Address) 2503 Elsmore Ave

15. DEC 4 - 1917 Filed ....., 191.....

ROBERT B. ABACHER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 3rd, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to, Dec 3rd, 1917, that I saw h.. alive on Dec 2nd, 1917, and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis of 1st with Uremic Stupor

(Duration) — yrs. — mos. — ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward L Gordon M. D.

12/3, 1917 (Address) 730 N. Mt Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: LOUDON PARK

DATE OF BURIAL: DEC 5 - 1917, 191.....

20-UNDERTAKER: ARMSTRONG-DENNY CO.

ADDRESS: 715 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10571 — 28 — D10571

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3407 Talbert st St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Aldrop

(Residence in Baltimore: No. 3407 Talbert st St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7-AGE: 62 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE (State or Country): Harford Co Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): "

12-MAIDEN NAME OF MOTHER: Mary E. Allsop

13-BIRTHPLACE OF MOTHER (State or Country): Harford Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm T. Williams

(Address) 2933 Rees st

15-

Filed DEC 4 - 1917, 191.....

ROBERT B. KRAUSE
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Emory Morrison M. D.
(Coroner)

Dec 4 1917 (Address) 7632 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Louisville Ky

19-PLACE OF BURIAL OR REMOVAL: Loudon

DATE OF BURIAL, Dec 4, 1917

20-UNDERTAKER: Mc R A Elliott

ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

D10572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10572

REGISTERED NO. C.....

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. ..... ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Harrison

(Residence in Baltimore: No. Little Sisters of the Poor St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, March 29, 1829
(Month) (Day) (Year)

7-AGE, 88 yrs. 8 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Samuel Harrison

11-BIRTHPLACE OF FATHER (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER Harriett Smith

13-BIRTHPLACE OF MOTHER (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- DEC 4 - 1917 ROBERT B. KRAUSER

Filed ..... 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3d, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 , that I saw h[er] alive on Dec 1 191 7 , and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic sclerosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Mann M. D.

Dec 4, 191 7. (Address) 1103 Valley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Dec 5, 191 7.

20-UNDERTAKER H C Wedefeld — ADDRESS 1st Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT. WITH ENDORSEMENT THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10573

D10573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Brentwood Av. St.; 10 WARD)

REGISTERED NO. C

2-FULL NAME Philip E Kernan

(Residence in Baltimore: No. 1111 Brentwood Av St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 16 (Month), (Day), 1851 (Year)

7-AGE, 66 yrs. 3 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Time Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) McShanes Foundry

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Kernan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Johanna Brennan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Kernan

(Address) 1111 Brentwood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 3 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1917, to Dec 3 1917, that I saw h m alive on Dec 2 1917, and that death occurred, on the date stated above, at 3.a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

Arteriosclerosis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

12-4, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Dec 5, 1917

20-UNDERTAKER J C Wyckoff

ADDRESS [illegible]

DEC 4 - 1917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D10574 Stiefel

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1917 D10574

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST. [illegible] WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Annabelle Stiefel

(Residence in Baltimore: No. 754 N. Eutaw St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married.

6-DATE OF BIRTH, Nov 9th (Month) ..... (Day), 1873 (Year)

7-AGE, 44 yrs. — 24 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Stolipher

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie E Kershner

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A E Bowell

(Address) 1830 Madison Ave

15-

Filed DEC 1 - 1917 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3rd (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1917, to Dec 3rd 1917, that I saw h[illegible] alive on Dec 3rd 1917, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

[illegible]

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremic coma

(Duration) ....yrs. ....mos. 1 ds.

(Signed) C. C. Childs M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at 754 N. Eutaw.

Former or usual residence 754 N. Eutaw St.

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL. Dec 5th 1917

20-UNDERTAKER Weisand & Co

ADDRESS 1733 N Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

(Over)

D10575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10575

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 613 S Bradford St ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma A. Kimmerle

(Residence in Baltimore: No. 613 S Bradford St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Sept 14 (Month) (Day), 1871 (Year)

7-AGE, 46 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James R Atwood

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Martha Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Kimmerle

(Address) 613 S Bradford St

15- DEC 4 - 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) Investigation find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Clinton Pyon M. D.
(Coroner)

Dec 4, 191 7 (Address) 16 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, [redacted] CAUSE OF BURIAL, [redacted], 191..

20-UNDERTAKER H Sanders Sons ADDRESS [redacted] 11th Floor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10576

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Marine Hospital 28 REGISTERED NO. C.....

CITY OF BALTIMORE. (No. U. S. Marine Hospital St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. R. Schoenfelder

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... June (Month) 15th (Day), 1865 (Year)

7-AGE, 52 yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 731
(a) Trade, profession, or particular kind of work Light house
(b) General nature of industry, business, or establishment in which employed (or employer) Keeper 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Schoenfelder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Schoenfelder

(Address) 735 S. Clover St.

15- DEC 4 - 1917 ROBERT B. BRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Dec 2 1917, that I saw h in alive on Dec 2 1917, and that death occurred, on the date stated above, at 10.55 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chr

Pulmonary (Surg. Hosp.)

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Intestinal

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Voge M. D.

Dec. 3, 1917. (Address) U.S. Marine Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 8 ds. In the State 17 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Not Known

Former or usual residence 735 S. Clover St.

19-PLACE OF BURIAL OR REMOVAL, St Paul's Cemetery — DATE OF BURIAL, Dec 5, 1917

20-UNDERTAKER J. Sander Sons — ADDRESS 1710 West N

17
38

D10577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10577

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1455 N. Bond ST. 15 WARD 19) REGISTERED No. C

2-FULL NAME Ernest Kaus

(Residence in Baltimore: No. 1455 N Bond St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... November ....., 1879
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Oil Co.

2 13

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edmund Kaus,

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Williams,

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Wife

(Address) 1455 N Bond St.

15- Filed DEC 4 - 1917, 191... ROBERT B. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 2 ....., 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

....., 191.. (Address) 819 N Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL | DATE OF BURIAL, DEC 3 - 1917, 19...

20-UNDERTAKER Commissioner Health. | ADDRESS

Burial Permit Issued

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10578

CERTIFICATE OF DEATH.

29 D10578

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 Summit ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles H Estep

(Residence in Baltimore: No. 1825 Summit St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 328

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. (Month) 29 (Day) 1865 (Year)

7-AGE, 49 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer). Stone Co

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thos. B. Estep.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna Morton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. [illegible]

(Address) 1825 Summit

15- DEC 4 - 1917 Filed....., 191.... ROBERT B. KRAUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 1 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said I (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Dec 8, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cy

DATE OF BURIAL, Dec. 5, 1917

20-UNDERTAKER Jos Joerdens, Son

ADDRESS 217 S Broa

D10579

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10579

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1151 N Carey. ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L. Hill

(Residence in Baltimore: No. 1151 N. Carey st St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: Bl

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (~~Write the word~~): Married

6-DATE OF BIRTH: Sept 4, 1866 (Month) (Day) (Year)

7-AGE: 51 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Coal and Wood Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE (State or country): Harford Co

PARENTS

10-NAME OF FATHER: John S. Hill

11-BIRTHPLACE OF FATHER (State or country): Harford Co

12-MAIDEN NAME OF MOTHER: Hannah Prebury

13-BIRTHPLACE OF MOTHER (State or country): Harford Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Hill

(Address) 1151 Carey St

15-

Filed DEC 5-1917, 191 ROBERT B. KRAUTER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 4, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1917, to Dec 4 1917, that I saw h~~im~~ alive on Dec 3, 1917, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Jules S Bischof M. D.

Dec 4, 1917 (Address) 828 N Carrollton C.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peters cemetery

DATE OF BURIAL: Dec. 6, 1917

20-UNDERTAKER: Felix B. Pyle

ADDRESS: 102 E. Mulberry St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10580

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1925 (St.) White (ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hatch Brown

(Residence in Baltimore: No. 1925 White St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, Aug. 21, 1909. (Month) (Day) (Year)

7-AGE, 8 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Waters, Bessie A.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. R. Fisher

(Address) 1925 White St.

15- DEC 4 - 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29 1917, to Dec 3 1917, that I saw him alive on Dec. 3 1917, and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows:

Bronchia-Pneumonia

Primary (Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Mal-nutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. H. Monkhouse M. D.

Dec 5, 1917. (Address) 303 W. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec. 5, 1917.

20-UNDERTAKER Felix B. Pyle ADDRESS 102 E. Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10581

CERTIFICATE OF DEATH.

92

D10581

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Baum

(Residence in Baltimore: No. 501 N. Stricker St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	widower

6-DATE OF BIRTH, Aug 31, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 11 3

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Baum

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Welch

13-BIRTHPLACE OF MOTHER (State or Country) Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Baum Jr.

(Address) 501 N Stricker St

15-

Filed ....., 191.....

Registrar.

DEC 4 - 1917 ROBERT R. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 4 1917, that I saw him alive on Dec 4 1917, and that death occurred, on the date stated above, at 3:55 p. m.

The CAUSE OF DEATH* was as follows:

..... Chronic Pneumonia .....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward L. Smith M. D.

Dec 4, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. 62 mos. ..... ds.

Where was disease contracted, if not at place of death? 501 N. Stricker St

Former or usual residence 501 N. Stricker St.

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, ..., 191.7

20-UNDERTAKER H. H. Tittle — ADDRESS 231 E Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D10582

CERTIFICATE OF DEATH.

120 D10582

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2240 Druid Hill Ave. St., 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. Penn.

(Residence in Baltimore: No. 2240 Druid Hill Ave. Ct. 53 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Nov. 30 (Month), (Day), 1864 (Year)

7-AGE, 53 yrs. mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Rubber

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, James Penn

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ruth — unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Penn

(Address) 2240 Druid Hill ave

15-

Filed....., 191.....

Registrar.

DEC 5 - 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 1st (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 191 7, to Dec. 1st 191 7, that I saw him alive on Dec. 1st 191 7, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 4 yrs. mos. ds.

(Signed) W. T. Carter M. D.

Dec. 4th, 191 7 (Address) 515 Mt. Vernon Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec. 5, 191 7

20-UNDERTAKER James H. Dennis — ADDRESS 1303 Freedman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10583

CERTIFICATE OF DEATH.

REGISTERED NO. C 5 / 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1116 Laurel ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Shorten

(Residence in Baltimore: No. 1116 Laurel St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, Adult
40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home work
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Police Dept.

(Address).....

15-

DEC 5 - 1917

Filed....., 191.....

ROBERT R. KRAUTER
Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)

.....find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

Sudden (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) W. J. Riley M. D.
(Coroner.)

Dec 3 -, 191.7. (Address) 1627 Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Dec 5, 1917

20-UNDERTAKER John W. Henderson

ADDRESS 314 Caroline

Spec.—5-19-13—M. & T.—500 Blks.

D10584 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10584

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Lombard St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. James

(Residence in Baltimore: No. 1229 Lombard St. St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Jan. 6, 1829
(Month) (Day) (Year)

7-AGE, 88 yrs. 10 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah E. Smaedon

(Address) 1229 W. Lombard St

15-

Filed DEC 5 - 1917 191.. ROBERT P. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 191 7, to Dec 3 191 7, that I saw him alive on Dec 3 191 7, and that death occurred, on the date stated above, at 4:30p m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Raymond G. Glenn M. D.

Dec 4, 191.. (Address) Not known

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Dec. 6, 191..

20-UNDERTAKER Jno Bloom

ADDRESS 1003 Madison Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Mad 3866

Spec.—8-24-14—M. & T.—2000 Blks.

D10585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10585

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Warren ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Anderson

(Residence in Baltimore: No. 626 Warren St.: Same yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home

8 7 6 0

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, James Anderson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sallie Young

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant), James Williams

(Address) 626 Warren St

15-

Filed DEC 5 - 1917, 191...

ROBERT R. KRAETZER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1917, to Dec 3 1917, that I saw h alive on Dec 2 1917, and that death occurred, on the date stated above, at 5a, m.

The CAUSE OF DEATH* was as follows:—

..... Bronchitis

..... Pulmonary Tuberculosis

.....

..... (Duration) 1 yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

..... (Duration) 1 yrs. 1 mos. 21 ds.

(Signed) C. N. Hincs M. D.

Dec 4, 1917 (Address) 712 S Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Dec 4, 191...

20-UNDERTAKER Dorsey Horsey

ADDRESS 1306 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10586

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 Stockholm ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Anderson

(Residence in Baltimore: No. 838 Stockholm St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Samuel Stuart

11-BIRTHPLACE OF FATHER (State or Country) Howard Co Md

12-MAIDEN NAME OF MOTHER Lidia Green

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Stuart

(Address) 838 Stockholm St

15-

Filed DEC ..... 1917 ..... 191 ..... ROBERT R. KRAUTER Burial Permit Clerk ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28 1917, to Dec 3 1917, that I saw h er alive on Dec 3 1917, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Inflam. Rheumatism

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) John Kelly Shaw M. D.

Dec 3 191 7. (Address) 729 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Arnold Station Co — DATE OF BURIAL, Dec 4, 1917.

20-UNDERTAKER Wm Hooper — ADDRESS 1106 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10587

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D10587

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 S Chester St ST.; E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Sileshy

(Residence in Baltimore: No. 8 S. Chester St St.; 33 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1869 (Year)

7-AGE, 48 yrs. — mos. — ds.

If LESS than 1 day, — hrs. or — min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

DEC 5 - 1917

Filed ....., 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3rd (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1917, to Dec 3 1917, that I saw him alive on Dec 3 1917, and that death occurred, on the date stated above, at 6.50 p.m.

The CAUSE OF DEATH* was as follows:

(a) Acute Lobar Pneumonia

.....

.....

..... (Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alfred A. Braddock M. D.

Dec 4, 1917. (Address) 818 Patterson Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Herron Rosedale

DATE OF BURIAL, 12-5, 1917

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D10588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10588

CERTIFICATE OF DEATH.

REGISTERED NO. C 130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2030 E. 31st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A. Dunlap

(Residence in Baltimore: No. 2030 E. 31st St.; 34 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 24 Mar 19 (Month) (Day), 1883 (Year)

7-AGE, 32 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Tranor

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Martha Ford.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Dunlap

(Address) 2030 31st st

15-

Filed....., 191..... Registrar.

ROBERT R. EMASTER
DEC 5 - 1917
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from dec 1 1917, to Dec 3 1917, that I saw h[illegible] alive on Dec 3 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Chronic Parenchymatous Nephritis (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic Pneumonia (Duration) 6 yrs. mos. ds.

(Signed) Reginald S Tonry M. D.

Dec 3, 1917. (Address) 414 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Dec 6, 1917

20-UNDERTAKER Helbert E Fuller — ADDRESS 221 N Bradford

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10589 92 D10589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Pascault

(Residence in Baltimore: No. 6 E. Read St.; 2 yrs., 8 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Nov. 20 (Month) (Day) 1878 (Year)

7-AGE. 39 39 yrs. 0 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Secretary
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis C. Parcault

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Henrietta Keech

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Henrietta Parcault

(Address) 1123 Druid ave

15-

Filed DEC 5 - 1917, 191... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30 1917, to Dec. 4, 1917, that I saw her alive on Dec. 4, 1917, and that death occurred, on the date stated above, at 6.45A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) ....yrs....mos. 2 ds.

(Signed) J. Edw. Norris M. D.

12/4/17, 191... (Address) St. Jos. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 5 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Don't Know.

Former or usual residence 6 E. Read Street.

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, 12—6—, 1917.

20-UNDERTAKER Henry W. Jenkins & Son

ADDRESS 1 McCulloh & Orchard Sts

Spec.—8-24-14—M. & T.—2000 Blks.

D10590

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D10590

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N. Eolington Ave WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Heuer

(Residence in Baltimore: No. 1812 N Eolington St. St.; 62 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 29 (Month) (Day), 1855 (Year)

7-AGE,	If LESS than 1 day,
62 Years 11 mos. 4 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Roof Tinner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Fredrick Heuer

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Heuer

(Address) 18 12 N Eolington Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6 P.M Dec 2 1917, to 6 A.M Dec 3 1917, that I saw h im alive on Dec 2 1917, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

12 hours (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Indefinite (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm J Watson M. D.

Dec 3, 191.. (Address) 1127 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Oak Lawn Cemetery	Dec 6th, 191..
20-UNDERTAKER	ADDRESS
George F. Ruth	1735 Hayford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 6 - 1917 ROBERT B. MEAGHER Burial Permit Clerk

Uncle

D1059T

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1059T

79

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1503 E Lafayette St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Umble

(Residence in Baltimore: No. 1503 E Lafayette, St.; yrs., 11 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer). Own, Self

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Geo Umble

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER E E Lantz

13-BIRTHPLACE OF MOTHER (State or Country), Harrs. md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Umble

(Address) 814 N Caroline

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Clerk
Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coron
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William Umble M. D.
(Coroner.)

Dec 7, 191.. (Address) 1735 Harford ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Pennsylvania Harford Co

DATE OF BURIAL, Dec 5, 19..7

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10592

CERTIFICATE OF DEATH.

120 ✓ D10592

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Bond ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Spencer

(Residence in Baltimore: No. 922 N. Bond St. St.; 20 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, August (Month) 19 (Day) 1835 (Year)

7-AGE, 82 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Librarian &c
(b) General nature of industry, business, or establishment in which employed (or employer): Knights of Pythias

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Thomas Spencer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rosetta Butler

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Hooper (Sister)

(Address) 1312 N. Eden St.

15-

Filed....., 191.

Registrar.

DEC - 1917 ROBERT E. RESLER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day) 191 7 (Year)

I HEREBY CERTIFY, That I attended deceased from November 22 191 7, to December 4 191 7, that I saw h m alive on December 3rd 191 7, and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

a Complication of

(Duration) 3 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. ds.

(Signed) Wm. H. T. Wagner M. D.

Dec. 4, 191 7 (Address) 703 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 9 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Dec 7, 191 7

20-UNDERTAKER H E Hughes 17

ADDRESS S Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10593 D10593

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 224 N Fulton av ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E. Ireland

(Residence in Baltimore: No. 2119 Lyndhurst ave St.; yrs., 24 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 24 (Day), 1852 (Year)

7-AGE, 65 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Life insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer): Metropolitan

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Ireland

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mary Mills

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Ireland

(Address) 2119 Lyndhurst Ave

15- ROBERT A. KRAUTER

Filed DEC 5 - 1917, 191. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

not known

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Rupture Coronary artery (Duration) ....yrs. ....mos. ....ds. Sudden

(Signed) James McFaulon M. D. (Coroner.)

Dec 4 1917 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Dec 6, 1917
20-UNDERTAKER Harry W. Ellen	ADDRESS 1944 W. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10594

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 Park Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Ineet.

(Residence in Baltimore: No. 829 Park Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...82.... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Mickelson

(Address) 829 Park Ave

15-

Filed DEC 5 - 1917, 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 3 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Dec 3 1917, that I saw h.. alive on Dec 3 1917, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

..... Chronic Hypertension .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno G Statler M. D.

Dec 3, 191... (Address) 206 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 5, 1917
20-UNDERTAKER	**ADDRESS**
Charles B Jones	2356 Pine

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHILE LEARNED, WITH UNPARALLELED

Spec.—8-24-14—M. & T.—2000 Bks.

D10595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10595

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1007 W Fulcrot ST. 16 WARD)

2-FULL NAME Jamko Satchell

(Residence in Baltimore: No.) 1007 Whalcoat St.; 40 yrs., mos. da.) 10 yrs at Whalcoat

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Married

6-DATE OF BIRTH. Unknown ....., 1856
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
61 yrs. ..... mos. ..... da.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Barber
(b) General nature of industry, business, or establishment in which employed (or employer).....

800

9-BIRTHPLACE, (State or Country). Accomac Co. Va

PARENTS.

10-NAME OF FATHER. James Satchell

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Jessie Tuckman

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie Carter

(Address) 1209 Ethnig St

15-

Filed DEC 5 - 1917, 191.....

ROBERT R. TRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 1917, to Dec 3 1917, that I saw h— alive on Dec 3 1917, and that death occurred, on the date stated above, at 5P. m.

The CAUSE OF DEATH* was as follows:

.....

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Angina

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm H Wright M. D.

Dec. 4.., 191.7 (Address) 1209 Pulaski St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Dec. 6., 191.7.
20-UNDERTAKER Sam'l W. Chase Jun	ADDRESS 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE FEARNET, WHITE UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10596

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D10596

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1054 Pulaski ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Alder Dingo

(Residence in Baltimore: No. 1054 Pulaski St.; 13 yrs., 10 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, Jan (Month) 25 (Day), 1904 (Year)

7-AGE,	If LESS than 1 day,
13 yrs. 10 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country). Balt Md

PARENTS.

10-NAME OF FATHER. Lawd Dingo

11-BIRTHPLACE OF FATHER (State or Country). Balt Md

12-MAIDEN NAME OF MOTHER Minnie Alder

13-BIRTHPLACE OF MOTHER (State or Country). Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. V. Hitchcock

(Address) 112 N. Carrollton Ave

15-

Filed DEC 5 - 1917, 191... ROBERT E. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1917, to Dec 2nd 1917, that I saw h[illegible] alive on Dec 2nd 1917, and that death occurred, on the date stated above, at 12 00 a m.

The CAUSE OF DEATH* was as follows:

Ivy Poison

Poison Ptomaine

(Duration) ....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos. 2 ds.

(Signed) C. V. Hitchcock M. D.

12/3, 191.7 (Address) 112 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Dec 5, 1917

20-UNDERTAKER Jam H. Chandler ADDRESS 1400 Mad Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10597 HEALTH DEPARTMENT—CITY OF BALTIMORE D10597

CERTIFICATE OF DEATH.

64

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 125 S Chapel ST.; V WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Noah

(Residence in Baltimore: No. 125 S Chapel St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct - (Month), (Day), 1856 (Year)

7-AGE, 61 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Martin Lehner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Johnson

(Address) 107 S Ellwood av

15- DEC 5 - 1917 ROBERT R. KRAUTER

Filed ....., 191... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Theresa Bryant Dunn Co. M. D. (Coroner.)

12/3, 191 7 (Address) 716 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, December 5 1917

20-UNDERTAKER Kendall & Jefferson — ADDRESS 3718 Wm

Spec.—8-24-14—M. & T.—2000 Bks.

627

D10598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10598

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 N Mount ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hill

(Residence in Baltimore: No. 1523 N Mount St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
43 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Hill

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Hill

(Address) 1523 N Mount st.

15-

Filed ....., 191.....
Registrar.

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Dec 2 1917, that I saw h[illegible] alive on Dec 2 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

fracture of neck
femur
acute

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) E. Wallace Levy M. D.

Dec 3, 191 7 (Address) 1721 Pennsylvania

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 6 191 7
20-UNDERTAKER Brown & Ireland	ADDRESS 114 N Schroeder st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D10599

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 9255 Sharp St ST. 23 WARD)
2-FULL NAME Irene Gray
(Residence in Baltimore: No. 9255 Sharp St)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 1 yrs., 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, July (Month) 9 (Day), 1916 (Year)

7-AGE, 1 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), md Balto.

PARENTS.

10-NAME OF FATHER, Irene Gray
11-BIRTHPLACE OF FATHER (State or Country), md
12-MAIDEN NAME OF MOTHER Mary Elkins
13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Elkins Gray
(Address) 9255 Sharp

15-
Filed DEC 5 1917., 191.. ROBERT R. KRAUTER Clerk.
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 4 1917, that I saw her alive on Dec 4 1917, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:
Acute Gastritis
(Duration) ....yrs. ....mos. 1 ds.
CONTRIBUTORY (Secondary) Gastro enteritis
(Duration) ....yrs. ....mos. 3 ds.

(Signed) J. Guy Bowley M. D.
12/4, 1917 (Address) 136 W. Lee St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn | DATE OF BURIAL, Dec 6, 191..

20-UNDERTAKER, L. V. Brauchle Sons | ADDRESS W. Monty

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10600

CERTIFICATE OF DEATH.

REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 D. Wilcox ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Jordan

(Residence in Baltimore: No. 922 D. Wilcox St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, December (Month) 1 (Day) (Year)

7-AGE 66 yrs. mos. ds.	If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cobbler
(b) General nature of industry, business, or establishment in which employed (or employer): Private 471

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abram Jordan

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Wrenin

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jordan

(Address) 922 W. Pratt St.

15-

Filed ....., 191.....

DEC 5 - 1917

ROBERT B. KRAUSE
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 4th, 191 7, to December 4th, 191 7, that I saw h[e] alive on December 4th, 191 7, and that death occurred, on the date stated above, at 4-40 a.m.

The CAUSE OF DEATH* was as follows:

Acute mania

4 hrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) ? yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

1214 E. Monument, 12th, 191 7, (Address) 922 Wilcox St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 922 David Wilcox Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Henry Run	Dec 5, 191 7

20-UNDERTAKER	ADDRESS
S. Levin & Bro	1107 E Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10601

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 1/2 W. Balto ST.; 18 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgania Weaver

(Residence in Baltimore: No. 824 1/2 W. Balto St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, December (Month) 25 (Day), 1867 (Year)

7-AGE. About 50 yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Dont Kum

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country). Dont "Kum"

12-MAIDEN NAME OF MOTHER Dont "Kum"

13-BIRTHPLACE OF MOTHER (State or Country). Dont Kum

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Marriott

(Address) 501 Penn ave City

15-

Filed DEC 5 - 1917, 191... ROBERT B. KRAUTER Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 3 1917, that I saw h-er alive on Dec 3 1917, and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) ...yrs. 6 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. Bruce Ross M. D.

Dec 5 1917. (Address) 729 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Wm. Cook — ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10602

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 E. Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David E.W. Hartzell

(Residence in Baltimore: No. 2222 E. Biddle St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, about 66 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ornamental Plaster
(b) General nature of industry, business, or establishment in which employed (or employer): 5

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, David Hartzell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary ?

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice Hartzell

(Address) 2222 E. Biddle

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 4 1917, that I saw him alive on Dec 4 1917, and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Dec 5, 1917. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western

DATE OF BURIAL, 12/7, 1917.

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave.

DEC 5 - 1917 Burial Permit Clerk

ROBERT B. KRAUTER

3 Cyl. 830 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMANENT, WITH CARBONIZING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10603

1-PLACE OF DEATH: CITY OF BALTIMORE: (No. Md. Gen. Hospital. Eutaw ave & Madison ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Kellner

(Residence in Baltimore: No. 100 Mc Mechen St. St.; 50 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, May 16 (Month) (Day), 1844 (Year)

7-AGE, 67 yrs. 6 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Musician (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Joseph Kellner.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorothea Kuon

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. M. Tries

(Address) 100 Mc Mechen

15- Filed DEC 5 1917, 191.. ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Dec 4 1917, that I saw h[illegible] alive on Dec 4 1917, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bladder Carcinoma of January

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12-4-, 1917. (Address) Md Gen Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 12 ds. In the State 67 yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence 100 Mc Mechen St.

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, Dec 7 1917

20-UNDERTAKER Lowe Cook — ADDRESS 1012 E Fayette

Spec.—5-19-13—M. & T.—500 Bks.

D10604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10604

REGISTERED No. C 479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen E. Pardoe

(Residence in Baltimore: No. 1424 McCulloh St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dont Know (Month) (Day), 1845 (Year)

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Dixon

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Martha Gott

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Barra E. Hunter

(Address) 1424 McCulloh St.

15-

Filed ..... 191.

ROBERT E. [illegible]
Burial Permit Clerk

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Since 1907, to Dec 4th 1917, that I saw h[illegible] alive on Dec 2d 1917, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

a. Mitral Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 18 yrs. mos. ds.

(Signed) C. A. Dewall M. D.

Dec 4, 191.. (Address) 181[illegible] N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Friends Cemetery DATE OF BURIAL, Dec 6, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1[illegible] Light

D10605

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10605

1 PLACE OF DEATH

REGISTERED NO. C 28

CITY OF BALTIMORE: (No. 656 W. Baltimore ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Kaylanchas

(Residence in Baltimore: No. 656 W. Baltimore St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Not known, (Month) (Day) 1 (Year)

7-AGE: 42 yrs. — mos. — ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Saber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Seikus

(Address) 656 W Baltimore

15-

Filed DEC 5 1917 ROBERT R. KRAUTH REGISTRAR

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1917, to, Dec. 5 1917, that I saw h[illegible] alive on Dec. 5 1917, and that death occurred, on the date stated above, at 12-10 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs 4 mos ds.

Contributory (SECONDARY)

(Duration) yrs mos ds.

(Signed) John A Tilesworthy M. D.

Dec 5, 1917 [Address] 138 Lexington Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence 656 W Baltimore St

19-PLACE OF BURIAL OR REMOVAL: St. Stanislowas

DATE OF BURIAL: Dec 7, 1917

20-UNDERTAKER: John Grabkiewicz

ADDRESS: 425 S Paca St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10606

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 W. Lafayette St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Lloyd

(Residence in Baltimore: No. 1324 W. Lafayette St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 7, 1853 (Month) (Day) (Year)

7-AGE, 63 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob DeShields

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Motten

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis A Lloyd

(Address) 1324 W. Lafayette

15-

Filed ....., 191.....

ROBERT B. KRAUTER
Registrar.

Dr Stillman - Carey - Lafayette.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 1917, to Dec 8 1917, that I saw her alive on Dec 4 1917, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) Hubert F. Haenman M. D.

Dec 8, 1917. (Address) 1324 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western

DATE OF BURIAL, 12-17, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 N Mid Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10607

CERTIFICATE OF DEATH.

120 D10607

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2000 East 31 st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Henderson

(Residence in Baltimore: No. 2000 East 31 st St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 13, 1863 (Month) (Day) (Year)

7-AGE, 54 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Arthur

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Phillips

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Henderson

(Address) 2000 East 31 st St

15-

DEC 5 - 1917

Filed....., 191.....

ROBERT B. KRAUER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1917, to Dec. 4, 1917, that I saw her alive on Dec. 4, 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Bronchitis

(Duration) 1 yrs. 2 mos. 4ds.

CONTRIBUTORY, (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Nathaniel F. Zapp, M. D.

Dec. 4, 1917. (Address) 7 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Dec. 7, 1917.

20-UNDERTAKER Sirkler & Sirkler

ADDRESS 1739 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10608

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

172

D10608

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1503 W.Baltimore St. St.; 19 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Webster P.George.

(Residence in Baltimore: No. 1503 W.Baltimore St St.; 1 yrs. 3 mos. 26 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male.	White.	Single.

6-DATE OF BIRTH: August, 7th. 1916. (Month), 1 (Day) (Year)

7-AGE: 1 yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Walter P.George.

11-BIRTHPLACE OF FATHER (State or country): Belair, Md.

12-MAIDEN NAME OF MOTHER: Myrtle I.Bohlman.

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs.Myrtle Bohlman.(mother)

(Address) 1503 W.Baltimore Md.

15. Filed DEC 5 - 1917, 191 ROBERT R. KRAUTER Registrar

Burial Permit (illegible)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 3rd. 1917. (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 2nd. 1917. to December 3rd 1917.

that I saw h in alive on December 3rd. 1917.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Meningitis.

(Duration) ..... yrs. ..... mos. 14 ds

Contributory (SECONDARY) Accidental fall down stairs.

(Duration) ..... yrs. 1 mos. 7 ds.

(Signed) Wm M Reinhardt M. D.

Dec, 4th. 1917. (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount Olivet Cy. DATE OF BURIAL: Dec 6 1917

20-UNDERTAKER: Jos Joerndt Son ADDRESS: 217 S. Pac

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10609

CERTIFICATE OF DEATH.

152

D10609

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Caplan

(Residence in Baltimore: No. Hebrew Hosp St.; yrs., mos. 6 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, November 29, 17
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — inf
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto., md.

PARENTS.

10-NAME OF FATHER, Sam Caplan

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Caplan

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Levy

(Address) 1411 E. Balto St

15-

DEC 5 - 1917

ROBERT R. KRAUTER
Burial Permit Clerk

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1917, to Dec 5 1917, that I saw h[illegible] alive on Dec 5 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumorrhagic Disease of Newborn

..... (Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) I Klaeobson M. D.

12/5, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 6 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 115 N Amm st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery — DATE OF BURIAL, Dec. 5, 1917.

20-UNDERTAKER Jack Levy — ADDRESS 1411 E Balto

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10610

CERTIFICATE OF DEATH.

1917 D10610

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Unknown ...St.: 16 WARD)

2-FULL NAME Joseph or Guyon Unknown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Unknown ...St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH About Dec. 2, 1913
(Month) (Day) (Year)

7-AGE. About yrs. mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Unknown

PARENTS.

10-NAME OF FATHER. "

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt. Jno. Kenney

(Address) North-West Side

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, About Dec. 2, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) T. Wotherspoon M. D.
(Coroner.)

Dec. 5, 1917. (Address) 819 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

DEC 5 1917 ROBERT R. KRAUTER Burial Permit Clerk

JOHNS HOPKINS HOSPITAL Commissioner Health

D10611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10611

CERTIFICATE OF DEATH.

189

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1136 3 months ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. unknown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 1 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- DEC 5 - 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: unknown cause, probably Exposure.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) James M Fenlon M. D. (Coroner.)

Dec 5, 1917 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER	ADDRESS

Burial Permit

133-13

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10612 **CERTIFICATE OF DEATH.** 91 D10612

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Univ Hospt ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irwin Randolph

(Residence in Baltimore: No. 930 Pear St St.: Temporary. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Black.	Single

6-DATE OF BIRTH, April (Month), (Day), 1916 (Year)

7-AGE, 1 yrs. 7 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Irwin Randolph.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Corine Rice

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

DEC 5 - 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30 1917, to Dec 1 1917, that I saw h er alive on Dec 1 1917, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

..... (Duration) unknown yrs. mos. ds.

CONTRIBUTORY..... (Secondary) Measles

..... (Duration) yrs. mos. ds.

(Signed) J. B. B. Cunningham M. D.

Dec 1, 1917 (Address) Univ Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. mos. 2 ds. In the State yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 930 Pear St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	DEC 3 1917 ....., 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D10613

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 252 N. Hoffman St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Stahlmann

(Residence in Baltimore: No. 252 N Hoffman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct. 4, 1917
(Month) (Day) (Year)

7-AGE. ....yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Mary Stahlmann

12-MAIDEN NAME OF MOTHER. Mary Stahlmann

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) Frederick Md.

15-

Filed ....., 191....

DEC 5 - 1917

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Iron Stomach Ulcer
Perforation
Peritonitis
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. Shearer M. D.
(Coroner)

Dec 4, 191.. (Address) 919 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER	ADDRESS
Commissioner Health,	

103-20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9w D10614

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Stephen 403 St. 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Webb.

(Residence in Baltimore: No. 407 S. Dallas St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 40 + yrs. mos. ds. | If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Dec 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) H. Friedenwald M. D.
(Coroner.)

Dec 26, 1917. (Address) 7 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

ROBERT B. KRAUTER
DEC 5 - 1917
Commissioner Health,

13839

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10615

CERTIFICATE OF DEATH.

1 D10615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 North Ave ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma V. Flagg

(Residence in Baltimore: No. 1715 North Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 8, 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Co. Md

PARENTS.

10-NAME OF FATHER, Henry A Owens

11-BIRTHPLACE OF FATHER (State or Country). Balto Co Md

12-MAIDEN NAME OF MOTHER Susanna Ritter

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE ~~IS~~ TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

DEC 5 - 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1917, to Dec 5 1917, that I saw h er alive on Dec 5 1917, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:
Hemorrhage of the Heart
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Typhoid Fever Primarilio 17
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Lincoln Holbrook M. D.
Dec 5, 1917 (Address) 2124 Loudon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem.	Dec 7., 1917.
20-UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10616 D10616

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Granada apts ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Strauss

(Residence in Baltimore: No. Granada apts. Lafayette Ave ST.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept 12, 1844
(Month) (Day) (Year)

7-AGE, 68 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Shirt Mfgr

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Philip Strauss

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo Jandorf

(Address) Granada apts

ed....., 191.....

Registrar.

ROBERT R. KRAUTER
DEC 5 - 1917
Registration Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Dec 3 1917, that I saw him alive on Dec 4 1917, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 5 1917, (Address) 1327 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bello Hebrew

DATE OF BURIAL, 12-7, 1917

20-UNDERTAKER J. A. Krebs Co

ADDRESS 16th Ward

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10617

CERTIFICATE OF DEATH.

92 D10617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Brunt ST.: 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Kirby

(Residence in Baltimore: No. 1935 Brunt St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Col	Widowed

6-DATE OF BIRTH, January (Month) 7 (Day) 1843 (Year)

7-AGE, 74 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Julia Coder

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Kirby

(Address) 1935 Brunt St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 3 1917, that I saw her alive on Dec 3 1917 and that death occurred, on the date stated above, at 10-30 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Age

(Duration) yrs. mos. ds.

(Signed) Wm. H. Wright M. D.

Dec 4, 1917 (Address) 209 Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, Dec 5, 1917

20-UNDERTAKER, Samuel H. Hembey ADDRESS 718 N. Eddie

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D-10618 HEALTH DEPARTMENT—CITY OF BALTIMORE D 10618

64

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Bolton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lonnie V. Holtz

(Residence in Baltimore: No. 1414 Bolton St.; Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): Married

6-DATE OF BIRTH: April 3, 1851 (Month) (Day) (Year)

7-AGE: 66 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer): at Home 037

9-BIRTHPLACE, (State or Country): Balto md

PARENTS.

10-NAME OF FATHER: Frederick Renoff

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Spencer

13-BIRTHPLACE OF MOTHER (State or Country): Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): George Holtz

(Address): 1414 Bolton St

15-

Filed....., 191.....

Registrar.

DEC 6 - 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: December 4, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28th 1917, to Dec 4th 1917, that I saw her alive on Dec 4th 1917, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. D. Lockwood M. D.

Dec. 5th 1917. (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Green Mount

DATE OF BURIAL: Dec. 7, 191 7.

20-UNDERTAKER: Wm. Cook

ADDRESS: 502 N. North Ave.

22 Eastwood - 8 E. Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D10619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10619

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gibson B. Paul

(Residence in Baltimore: No. 1915 W. Northern Ave St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 11 (Month), 1850 (Day), (Year)

7-AGE, 66 yrs. 11 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None formerly
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer - Dec

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, J. S. Paul

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Recvt

(Address) Mercy Hosp.

15-

Filed ....., 191.....

ROBERT R. KRAUTER
DEC 5 1917
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1917, to Dec 5 1917, that I saw him alive on Dec 5 1917, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 mos 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward L. Dent M. D.

Dec 5, 191.7 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 5 mos. 5 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? 1915 W. Northern

Former or usual residence 1915 W. Northern

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 7, 191.7

20-UNDERTAKER Josiah Seyfert ADDRESS 600 W North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10620

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10620

Registered No. C 79

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 703 N. Baltimore St.: 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotta Grace

(Residence in Baltimore: No. 703 N. Baltimore St.: 76 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Nov (Month) 12 (Day), 1835 (Year)

7-AGE: 72 yrs. — mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): No

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: John Bowman

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Ellen Roach

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nan E. Grace

(Address) 1 West Lanvale

15.

Filed ....., 191.... ROBERT B. KRAUTER Registrar of Vital Statistics

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December (Month) 3 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 191—, to. Dec 3 191 7.

that I saw h— alive on December 3, 191—.

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Heart

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Bronchitis

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Edwin R. Ballard M. D.

Dec 3, 191 7 (Address) 1 West Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Balto Cemetery

DATE OF BURIAL: Dec 6 191 7

20-UNDERTAKER: Josiah Seffer

ADDRESS: 1600 W Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10621

CERTIFICATE OF DEATH.

D10621

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 22 Caldwell WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita Zini

(Residence in Baltimore: No. 652 W. Barre St. St.; ..... yrs., 3 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	child

6-DATE OF BIRTH, August (Month) 9th (Day) 1917 (Year)

7-AGE, ...yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Nicholas Zini

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Anna —

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Wheatley for C. P. D.

(Address).....

15-

Filed....., 191.....

Registrar.

DEC 6 - 1917 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1917, to Dec. 5, 1917, that I saw h[illegible] alive on Dec 5, 1917, and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ....yrs. 2 mos. 26 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. R. Michelstaetter M. D.

Dec. 5, 1917 (Address) U[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 26 ds. In the State yrs. 3 mos. 26 ds.

Where was disease contracted, if not at place of death? Malnourished from birth

Former or usual residence 652 W. Barre St. Balto

19-PLACE OF BURIAL OR REMOVAL St Peters Cemetery — DATE OF BURIAL, Dec 7, 1917

20-UNDERTAKER W. E. Cook — ADDRESS 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10622 HEALTH DEPARTMENT—CITY OF BALTIMORE D10622

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Davis

(Residence in Baltimore: No. 1635 Division St.; ....yrs,, ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Bl

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, [illegible] (Month) (Day) 1852 (Year)

7-AGE, 65 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Washington

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis A. Davis

(Address) 1635 Division St

15-

Filed ....., 191....

Registrar.

DEC 6 1917 Burial Permit ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917 (Month) (Day) (Year)

17) I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 5 1917, that I saw h[illegible] alive on Dec 5 1917, and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

Heart Disease

Indefinite

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) B. Garland Schmelz M. D.

Dec 6, 1917 (Address) 1534 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, Dec 6, 1917

20-UNDERTAKER Geo H Holland | ADDRESS 1631 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10623

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 22 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pat. J. Feaney

(Residence in Baltimore: No. 49 E York St.

St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	single

6-DATE OF BIRTH,

....., 1865.
(Month) (Day) (Year)

7-AGE,

52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

243 040

9-BIRTHPLACE. (State or Country),

Ireland

PARENTS.

10-NAME OF FATHER, John Feaney

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mc Dempsey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Haase

(Address) 619 Light St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

November 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1917, to Nov. 3 1917, that I saw h[illegible] alive on Nov. 3 1917, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

.....

Pneumonia, Lobar, Left Lung

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. McAllen M. D.

11/5, 1917. (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. Life mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 49 E York St

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem. DATE OF BURIAL, Nov. 7th, 1917.

20-UNDERTAKER M. Caryle & Son ADDRESS 1[illegible]5 E. Lee St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10621

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 D10621

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2941 N Charles St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie McPhail

(Residence in Baltimore: No. 2941 N Charles St

St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Feby 19 (Month) (Day), 1843 (Year)

7-AGE 77 yrs. 9 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework

037

9-BIRTHPLACE (State or country) Canada

PARENTS

10-NAME OF FATHER Wm McCubbin

11-BIRTHPLACE OF FATHER (State or country) Scotland

12-MAIDEN NAME OF MOTHER Lindsay

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John McPhail

(Address) 2941 N Charles

15

Filed 191

DEC 6 1917 ROBERT B. KRAUTER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 4 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 28, 1917, to Dec 4 1917, that I saw h[illegible] alive on Dec 4, 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. ds

Contributory (SECONDARY) Pulmonary oedema

(Duration) yrs. mos. ds.

(Signed) Harry Adler M. D.

Dec, 1917 (Address) 1178 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount

DATE OF BURIAL Dec 7, 1917

20-UNDERTAKER H. Dieckmann Sons

ADDRESS Monroe

Spec.—8-24-14—M. & T.—2000 lbs.

Helen Maselowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10625

CERTIFICATE OF DEATH.

15 D10625

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Fleet St., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Maselowski

(Residence in Baltimore: No. 1923 Fleet St.: yrs., 1 mos. 21 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Oct 14 (Month) (Day) 1916 (Year)

7-AGE: yrs. 1 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ——— 800
(b) General nature of industry, business, or establishment in which employed (or employer): ——— 800

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Vincent Maselowski

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Anna Gefowicz

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Vincent Maselowski

(Address): 1923 Fleet St.

15-

Filed....., 191.....

Registrar.

ROBERT R. KRAUTER
Registrar of Vital Records

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191 7, to Dec 22 191 7, that I saw h Sr alive on Dec 22 191 7, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Brand M. D.

Dec 22, 191.. (Address) 708 Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Dec 6th, 191.7

20-UNDERTAKER: M. F. Sadowski ADDRESS: 705 S. Ann St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 190 Aliceanna St.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dombeck

(Residence in Baltimore—No. 190 Aliceanna St

St.; 42 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	M

6-DATE OF BIRTH, ..., 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Dombeck

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Katherine —

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Steven Dombeck

(Address) 190 Aliceanna St

15-

Filed....., 191.....
Registrar.

ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Thomas Finn Emerson M. D.
(Coroner.)

Dec 5, 1917. (Address) 610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL,
St. Stanislaus.	DEC 7, 1917
20-UNDERTAKER	**ADDRESS.**
W. F. Sadowski.	705 S. Ann

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10627

Denny Gibson

D10627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lowell Pratt St. and Mercy Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Gibson

(Residence in Baltimore: No. 1370 N. Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	M

6-DATE OF BIRTH, Unknown (Month) (Day) 1872 (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Gibson

(Address) 616 Baker St

15-

Filed....., 191.....

Registrar.

ROBERT R. KRAUTZ
DEC 6 1917
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Uremia & Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. ds.

(Signed) W. H. Kelly M. D.
(Coroner.)

Dec 5, 1917. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 day In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 8, 1917

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 N Carey

D10628

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 ✓ D10628

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Harford av St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George C. Hademann

(Residence in Baltimore: No. 1718 Harford av St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	Single

6-DATE OF BIRTH: aug (Month) 25 (Day), 1895 (Year)

7-AGE: 22 yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Draughtsman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Chas A. Hademann

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Katherine Kaiser

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. A. Hademann

(Address) 1718 Harford ave

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 3 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14, 1914, to, Dec 3 1917, that I saw h.. alive on Dec 3 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) yrs mos ds.

Contributory (SECONDARY) .....

..... (Duration) yrs mos ds.

(Signed) John W. Anderson M. D.

Dec 4, 191 [Address] 1714 Eutaw pl

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 6, 191

20-UNDERTAKER: George F. Routh

ADDRESS: 1735 Harford ave.

DEC 6-1917 ROBERT B. KRAUTER Special Permit Clerk

961

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 3 WARD)

REGISTERED No. C 1752 D10629

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Rappazzo

(Residence in Baltimore: No. 213 Albemarle St. St.; yrs., 6 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Charles Rappazzo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Carmella Fazio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Rappazzo

(Address) 213 Albemarle St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following crushing of leg - accidentally run over by auto (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Luby (Coroner.) M. D.

Dec 6, 1917. (Address) 1637 Kerr

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Sacred Heart

DATE OF BURIAL, Dec. 6, 1917.

20-UNDERTAKER Frank Crack Son

ADDRESS 1906 Eastlord

DEC 6 - 1917 ROBERT R. KRAUTER Burial Permit

Spec.—8-24-11—M. & T.—2000 Bks.

D10630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10630

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 W. La Fayette ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Ann Penn

(Residence in Baltimore: No. 1008 W. La Fayette St.; 50 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) 1 (Day), 1843 (Year)

7-AGE, 74 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Levin Fenton

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Penoply Pollock

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. Martin Granddaughter

(Address) 1008 W. La Fayette

15-

Filed....., 191.....

Registrar.

DEC 6 - 1917

ROBERT R. KRAUTER
CHIEF CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8 1916, to Dec. 4 1917, that I saw h[illegible] alive on Dec. 4th 1917, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bone of Face

..... (Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cancer

..... (Duration) yrs. mos. ds.

(Signed) Edward Horn M. D.

Dec 5, 1917 (Address) 1 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec. 6, 1917

20-UNDERTAKER H. M. Poulson

ADDRESS 1307 Druid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10631

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

D10631

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 329 E. Hamburg ST.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie McGill

(Residence in Baltimore: No. 329 E. Hamburg St.: yrs. mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6-DATE OF BIRTH Nov 24, 1917 (Month) (Day) (Year)

7-AGE ..... yrs. ..... mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER Charles Gibson McGill

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Kathleen Cuttis

13-BIRTHPLACE OF MOTHER (State or country) W. Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Gibson McGill

(Address) 329 E Hamburg St

15.

Filed DEC 6 1917, 191 ROBERT [illegible] Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 6, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1917, to Dec 6th 1917, that I saw h[illegible] alive on Dec. 4th, 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

(Duration) yrs. mos 12 ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Harry C Coburn M. D.

12-6, 1917 (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Dec 7, 191[illegible]

20-UNDERTAKER Armstrong Denny Co

ADDRESS 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D. 10632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 10632

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 E Preston ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanne Carlton Ensor

(Residence in Baltimore: No. 1019 E Preston St.: 83 yrs., 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 29th (Day), 1834. (Year)

7-AGE, 83 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Martin Chanceaulme

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Susan Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), U. S. A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Ensor

(Address) 1019 E Preston

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 5 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 191 7, to Dec. 5, 191 7, that I saw h[illegible] alive on Dec. 5, 191 7, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, chronic nephritis

(Duration) 3 Months

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 5th, 191 7 (Address) 1019 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec. 7th, 191 7.

20-UNDERTAKER George Schilling & Sons

ADDRESS 112 E Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D-10633. HEALTH DEPARTMENT—CITY OF BALTIMORE D-10633.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N. Collington Ave St.; ..... WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Cochran Clift

(Residence in Baltimore: No. 515 Collington Avenue North St.; 35 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, ... Jan 30th, (Month) (Day) 1877 (Year)

7-AGE, 40 yrs. 10 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Justice of
(b) General nature of industry, business, or establishment in which employed (or employer): Peace

9-BIRTHPLACE, (State or Country): Lynchburg Va

PARENTS.

10-NAME OF FATHER: Josiah Clift Jr

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Alice Walker

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julian Clift

(Address) 515 N. Collington Av

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th, (Month) (Day) 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 2nd 191 7, to November 7th 191 7, that I saw him alive on November 7th 191 7, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis with Uraemia

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 ds.

(Signed) G. Lynn Sibley M. D.

Dec 4th, 191 7. (Address) Richmond Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Dec 7, 191 7

20-UNDERTAKER Philip Herring

ADDRESS 2016 Alameda

DEC 6 - 1917 ROBERT B. ERNSTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10634 D10634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perry Ford.

(Residence in Baltimore: No. Mercy Hospital St.; W yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Not known ....., 1 .....
(Month) (Day) (Year)

7-AGE, X yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records Mercy Hospital

(Address) .....

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1917, to Dec 3 1917, that I saw him alive on Dec 3 1917 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Labor ½ hour

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Edward H. Dorsett M. D.

Dec 3, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Evansville Ind.

Former or usual residence Evansville Ind.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 7, 1917

20-UNDERTAKER A. J. Ulmer — ADDRESS 1253 Fall Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10635

CERTIFICATE OF DEATH.

40 D10635

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S Chapel ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walberg'd Stock

(Residence in Baltimore: No. 113 S Chapel St.; 60 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, December 9, 1836 (Month) (Day) (Year)

7-AGE, 80 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER — Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stock

(Address) 113 S Chapel

15- DEC 6 - 1917 ROBERT H. KRAETER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1915, to Dec 4 1917, that I saw her alive on Dec 3 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

about 2

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 2 yrs. ....mos. ....ds.

(Signed) Geo. Keller M. D.

12-5-, 191.7 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 7, 191..

20-UNDERTAKER Randall Wyffel & Sons — ADDRESS 37 S ...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10636

CERTIFICATE OF DEATH.

120 D10636

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Collins Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Carrell

(Residence in Baltimore: No. 114 Collins Ave St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1856 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 3 mos. 19 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER, Gotlieb Eitel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Suckow

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Royston

(Address) 2836 Auburn Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1917, to Dec 4 1917, that I saw h[illegible] alive on Dec 3 1917, and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Industrial Lephritis

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

..... (Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Jacob Frosh M. D.

Dec 5 191.. (Address) 1822 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 7, 1917
20-UNDERTAKER	ADDRESS
Wendell Wyffels	3738 R

DEC 6 - 1917 ROBERT B. KRAUTER REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Blks.

D10637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10637

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Benson ST. 13 WARD)

2-FULL NAME Bessie E Wright-Jenkins

(Residence in Baltimore: No. 3520 Benson St.

St.; yrs., 4 mos. 29 ds.)

†If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Child

6-DATE OF BIRTH, July (Month) 6. (Day), 1917. (Year)

7-AGE, ...yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, Claude Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Wright

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wright

(Address) 3520 Benson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 191 7, to Dec. 4 191 7, that I saw her alive on Dec. 4 191 7, and that death occurred, on the date stated above, at 9:40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ....yrs. 2 mos. ....ds.

(Signed) C. Flaugher M. D.

12/5, 191.7 (Address) 3701 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cem'y | DATE OF BURIAL, Dec 7 ....., 191..

20-UNDERTAKER Unwith & Son | ADDRESS 307 Cathedral

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10638

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 10638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 2713 Huntingdon Ave. (ST.) (WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Ginsberman

(Residence in Baltimore: No. 2713 Huntingdon Ave. St.; 86 yrs., — mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Nov. 14, 1831
(Month) (Day) (Year)

7-AGE, 86 yrs. — mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Langley.

(Address) 2713 Huntingdon Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28 191.., to Dec 5 191.., that I saw h-er alive on Dec 5 191.7, and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

.....
.....
Paralysis
.....
..... (Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hem. Indigestion
2 months (Duration).....yrs.....mos.....ds.

(Signed) R. Leitch Wilson M. D.

Dec 5, 1917 (Address) 113 W. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Dec. 8, 1917
20-UNDERTAKER Ellenworth & Son	ADDRESS 367 Cathedral

DEC 5-1917 ROBERT P. KRAUTER BURIAL PERMIT CLERK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10639 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10639

45

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 1700 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. Burt Swindell

(Residence in Baltimore: No. 2519 N. Calvert St. St.; 30 yrs., 11 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	married

6-DATE OF BIRTH. Dec 31st, 1887 (Month) (Day) (Year)

7-AGE. 30 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sales + Advertising
(b) General nature of industry, business, or establishment in which employed (or employer): manager Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. David Swindell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Minnie Dorschal

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D. Worthington

(Address) 2519 N. Calvert St. Balto.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 6, 1917, that I saw h[im] alive on Dec. 6 1917, and that death occurred, on the date stated above, at 4:20 A m.

The CAUSE OF DEATH* was as follows:

Nephritis Acute

(Duration)....yrs....mos. 10 ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration)....yrs....mos....ds.

(Signed) G. R. Micklett M.D.

....., 191... (Address) 14 E. P. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State 30 yrs. 11 mos. 6 ds.

Where was disease contracted, if not at place of death?..... At residence

Former or usual residence 2519 N. Calvert St. Balto.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount	....., 191...
20-UNDERTAKER Wm. Cook	ADDRESS 502 E. North

(Over)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10640

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D10640

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 864 St Peter St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R. Polk

(Residence in Baltimore: No. 864 St Peter St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: May 23 (Month), 1863 (Day), (Year)

7-AGE: 54 yrs. 6 mos. 13 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: McTabe

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Polk.

(Address) 864 St Peter

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1917, to, Dec 6 1917, that I saw h.. alive on Dec 5 1917, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

..... (Duration) yrs ..... mos. 3 ds.

Contributory (SECONDARY) Chronic Nephritis

..... (Duration) yrs 6 mos. ..... ds.

(Signed), Elmer Schumansburg M. D.

Dec 7, 1917. [Address] 1107 W Lexington

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: Dec 8th 1917

20-UNDERTAKER: F. A. Penause

ADDRESS: 703 S Hanover

DEC 6 1917 ROBERT B. CRAUTER

REGISTRAR

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10641

CERTIFICATE OF DEATH.

91 D10641

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 368 E. Fay ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Liberatini

(Residence in Baltimore: No. 368 E. Fay St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Single

6-DATE OF BIRTH, ...May.... (Month) ....14.... (Day) ....16.... (Year)

7-AGE,	If LESS than 1 day,
....1....yrs....6....mos....22....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Liberatini

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Angelina Tarr

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 191.., to Dec. 6 191.., that I saw him alive on Dec. 5 191.., and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) about 10 wks. yrs....mos....ds.

(Signed) Wm. Lawrence M. D.

Dec 6, 1917. (Address) 5 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cemetery	Dec 7.., 191..
20-UNDERTAKER	ADDRESS
George F. Routh	1735 Harlem Ave

DEC 6 - 1917 ROBERT R. FRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10642

CERTIFICATE OF DEATH.

89

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1224 Chatham ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Foulks

(Residence in Baltimore: No. 1224 Chatham St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 5 yrs. — mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Richard Foulks

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Martha Pryor

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Green

(Address) 1224 Chatham St

15-

Filed....., 191.....

Registrar.

DEC 6 - 1917 ROBERT R. KRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1917, to Dec. 4, 1917, that I saw her alive on Dec. 4, 1917, and that death occurred, on the date stated above, at 8:40 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bronchitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. A. Colston M. D.

12/5, 1917. (Address) 1520 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dellville Station Va

DATE OF BURIAL, Dec. 9, 1917.

20-UNDERTAKER Nottingham & Ellison

ADDRESS 504 East St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10643

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D10643

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 324 N. Carrollton Av ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Ortman,

(Residence in Baltimore: No. 324 N. Carrollton Av St.; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Sept 30, 1830 (Month) (Day) (Year)

7 AGE: 87 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 900

9 BIRTHPLACE (State or country): Worcester, Md.

PARENTS

10 NAME OF FATHER: Homer Ortman

11 BIRTHPLACE OF FATHER (State or country): near Harpers Ferry Va.

12 MAIDEN NAME OF MOTHER: Mrs. Silsmun

13 BIRTHPLACE OF MOTHER (State or country): Harpers Ferry Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelaide Ortman
Mrs C. Eck, M.D.

(Address) 324 N. Carrollton Av

15.

Filed , 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 4th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11th, 1916, to Dec 4th 1917, that I saw him alive on Dec 4th, 1917, and that death occurred, on the date stated above, at 8.00 P.M. The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. 2 mos. 23 ds

Contributory (SECONDARY): Apoplexy (Cerebral Hemorrhage)

(Duration) 1 yrs. 1 mos. 23 ds.

(Signed) Charles Eck M. D.

Dec 5th, 1917 (Address) 111 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: 12-6-1917

20 UNDERTAKER: H. C. Brauning Son — ADDRESS: 517 W. Saratoga St

DEC 6 - 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10644

HEALTH DEPARTMENT—CITY OF BALTIMORE

93

D10644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 Edmondson Ave St.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson Spurrier

(Residence in Baltimore: No. 2035 Edmondson ave St.; 69 yrs., 11 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 2, 1848 (Month) (Day) (Year)

7-AGE, 69 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired - Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 009

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Wisdom Spurrier

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Eliza Spurrier

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary V. Whaley

(Address) 736 N. Fulton

15-

Filed....., 191.....

Registrar.

Dr Shook 806 N Fulton

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 191.., to ..... 191.., that I saw h.. alive on ..... 191.., and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk

DATE OF BURIAL, Dec 3, 191..

20-UNDERTAKER Wm. Cook

ADDRESS 602 E. North

DEC 3 - 1917 ROBERT B. KRAUTER REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10645

CERTIFICATE OF DEATH.

D10645

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 N Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Steinmueller

(Residence in Baltimore: No. 533 N. Stricker St.; 74 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Feby 1st, 1835
(Month) (Day) (Year)

7-AGE, 82 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker.
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1917

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Steinmueller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Steinmueller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Walter

(Address) 533 N. Stricker St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1917, to Dec 4th 1917, that I saw h[illegible] alive on Dec. 4th 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) yrs. mos. ds.

(Signed) Herman J. Evans M. D.

Dec 5th, 191.7 (Address) 833 N. Fulton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec. 7th 191.7

20-UNDERTAKER L. Schloman & Son — ADDRESS 1039 Hanover St.

D10646

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10646

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1429 Hanover St. ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Williamson

(Residence in Baltimore: No. 1429 Hanover St.: 39 yrs. 11 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec. 14th, 1877 (Month) (Day) (Year)

7-AGE: 39 yrs. 11 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Frame Maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: James Williamson

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Magdalene Grebe

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Williamson

(Address) 1429 Hanover St.

15.

Filed ..... 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 6th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 191..., to. Dec 6th 1917.

that I saw h... alive on Dec 6th, 191...

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... yrs. 11 mos. 6 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arthur L. Flinn M. D.

6....., 191... (Address) 1015 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Dec 8th, 1917

20-UNDERTAKER: E. Schlomann Son

ADDRESS: 1039 Hanover St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10647

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Argyle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Wiley

(Residence in Baltimore: No. 1226 Argyle St.; 19 yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) ....., 1897 (Year)

7-AGE, 19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thos B Steel

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Josephine Steel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Wiley

(Address) 1226 Argyle Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 4 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Dec 4 1917, that I saw h m alive on Dec 3d 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chill Birth

(Duration) yrs. 9 mos. ds.

(Signed) J. D. Gilbert M. D.

Dec 5, 191.. (Address) 1226 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, ..., 191..

20-UNDERTAKER Samuel A Lemley — ADDRESS 578 W Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

D10648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10648

CERTIFICATE OF DEATH.

26

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Orchard ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burley L. Richardson

(Residence in Baltimore: No. 547 Orchard St.: yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, (Month) Decem (Day) (Year) 1895

7-AGE, 22 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Centre Hill - Florida

PARENTS.

10-NAME OF FATHER, William Jackson

11-BIRTHPLACE OF FATHER (State or Country), North Carolina.

12-MAIDEN NAME OF MOTHER Susie Franklin

13-BIRTHPLACE OF MOTHER (State or Country), Florida

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jackson

(Address) 547 Orchard St.

15-

Filed ....., 191....

ROBERT R. KRAUTER

DEC 7 - 1917 BURIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) December (Day) 6th, (Year) 1917.

17- I HEREBY CERTIFY, That I attended deceased from November 15 1917, to December 6 1917, that I saw h[illegible] alive on December 5th 1917, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Bertha E. Tapman M. D.

Dec. 6, 191 7 (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 12/9, 191 7

20-UNDERTAKER Samuel F Hemsley — ADDRESS 578 N Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10649 D10649

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 N. Charles ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Galiaur—

(Residence in Baltimore: No. 2626 N. Charles St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...May.... (Month) 15th (Day), 1857 (Year)

7-AGE, 60 yrs. — mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Automobile.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Sales.....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Patrick Galiaur

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Powell

13-BIRTHPLACE OF MOTHER (State or Country), England—

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Powell Galiaur

(Address) 2626 N. Charles St.

15-

Filed....., 191.....

DEC 7 - 1917 ROBERT R. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...December.... (Month) 5 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~11~~ 11/28 1917, to 12/5/ 1917, that I saw h.. alive on 12/5 1917, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

.....Bronchio Pneumonia.....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Dilated Heart

..... (Duration) ....yrs. ....mos. 3 ds.

(Signed) ....J. W. D. E. Holt M. D.

12/7/, 191.. (Address) 2626 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mew Cathedral

DATE OF BURIAL, Dec 8, 191.7

20-UNDERTAKER C. H. Greenhalgh

ADDRESS 1624— Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D10650 HEALTH DEPARTMENT—CITY OF BALTIMORE D10650

CERTIFICATE OF DEATH.

X91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.; 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Brown

(Residence in Baltimore: No. Court Road - P. Rosedale St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ... (Month) January (Day), 1 (Year)

7-AGE, 70 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Brown

(Address) Perkins

15-

Filed ....., 191.... Registrar.

ROBERT B. KRAUTER
Dec 1 - 1917
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 - 1917, to Dec 6 - 1917, that I saw h.. alive on Dec 6 - 1917, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho-pneumonia

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Benj. M. Lotter M. D.

Dec ..., 191... (Address) Md General Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Court Road - P. Rosedale

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Dec 6, 1917

20-UNDERTAKER C. D. Kluft

ADDRESS Pikesville

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10651

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Gilmor ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Baker Gilbert

(Residence in Baltimore: No. 1325 Gilmor St.; 86 yrs. ... mos. ... da.)

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, March (Month) 7th (Day), 1832 (Year)

7-AGE, 85 yrs. 8 mos. 29 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Florist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Harford Co, Md

PARENTS.

10-NAME OF FATHER, Taylor Gilbert

11-BIRTHPLACE OF FATHER (State or Country). Harford Co Md

12-MAIDEN NAME OF MOTHER Sophia Baker

13-BIRTHPLACE OF MOTHER (State or Country). Harford Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Preece

(Address) 3036 W. North Ave

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 31 1917, to Dec 6 1917, that I saw him alive on Dec 5th 1917, and that death occurred, on the date stated above, at 10 00 a. m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

Several years (Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Chronic Pneumonia (Duration) Several years

(Signed) Wm McKaun M. D.

Dec 6, 1917 (Address) 1323 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Md — DATE OF BURIAL, Dec 7, 191...

20-UNDERTAKER W. J. Gutheim & Son — ADDRESS Baltimore Md

DEC 7 - 1917 ROBERT R. KRAUSE Burial Permit Clerk

D10652

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 D10652

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No 1633 N. Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Duncan

(Residence in Baltimore: No. 1633 N Carey St.; 49 yrs. 10 mos. ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Wht

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Feby 6th (Month) (Day), 1868 (Year)

7-AGE: 49 yrs. 10 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Wm Jno. Duncan

11-BIRTHPLACE OF FATHER (State or country): Md or Pa.

12-MAIDEN NAME OF MOTHER: Martha Waterbury

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Duncan

(Address) 1633 N. Carey St.

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 6th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 1916, to, Dec 6 1917, that I saw h.. alive on Dec. 6th 1917, and that death occurred, on the date stated above, at 7th P m.

The CAUSE OF DEATH* was as follows:

Lead Poisoning, followed by Progressive Paralysis

(Duration) 2 yrs, mos. ds.

Contributory (SECONDARY) Fract. Ankle

(Duration) yrs 3 mos. ds.

(Signed), E. Bauer M. D.

Dec. 6, 1917. [Address] 1605 N. Monk St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Dec 10th, 1917

20-UNDERTAKER: Jos. B. Cook ADDRESS 1103 N. Balto St.

DEC 7 - 1917 ROBERT R. KRAUSS Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10653

CERTIFICATE OF DEATH.

28 D10653

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Woodward ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther M. Trott

(Residence in Baltimore: No. 805 Woodward St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Aug. (Month) 23 (Day), 1900 (Year)

7-AGE,	If LESS than 1 day,
17 yrs. 3 mos. 11 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cigar Packer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Clarence E. Trott

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah E. Trott

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST ~~OF~~ OF MY KNOWLEDGE.

(Informant) Ruth Trott

(Address) 805 Woodward St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 4 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Dec 4 1917, that I saw h er alive on Dec 4 1917, and that death occurred, on the date stated above, at 10.35 p. m.

The CAUSE OF DEATH* was as follows:

..... Carcinoma Intestines

..... (Duration).....yrs. 5 mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) H. Mosley Hoge M. D.

Dec 5, 1917. (Address) 806 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec. 7th, 1917.
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

344

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10651 D10651

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Md. General Hosp. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin O. Ewing

(Residence in Baltimore: No. 1935 Harlem Ave St.; ..... yrs., ... mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) (Married)

6-DATE OF BIRTH, aug. 29, 1852 (Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edwin Ewing

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Osborn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Ewing

(Address) Havre de Grace Md

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1- 1917, to Dec 6- 1917, that I saw him alive on Dec 6- 1917, and that death occurred, on the date stated above, at 8.a.m.

The CAUSE OF DEATH* was as follows:

Encephalomalacia - Myelo-Malacia ?
Cause unknown

(Duration) yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emma M. Ewing M. D.

Dec 6-, 191.. (Address) Md Havre de Grace

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Pa.

19-PLACE OF BURIAL OR REMOVAL Harford Co. Md Wesleyan Chapel

DATE OF BURIAL, Dec. 8., 1917.

20-UNDERTAKER John O. Tunctree

ADDRESS 120 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. DO NOT USE PENCIL. MAKE NO ERASURES. DO NOT WRITE ON THIS SPACE RESERVED FOR REGISTRY RECORD

DEC 7 - 1917 ROBERT B. KRAUTER Burial Permit Clerk

Spec.—5-19-13—M. & T.—500 Blks.

D10655 HEALTH DEPARTMENT—CITY OF BALTIMORE D10655

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Thomas Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdalena Baer

(Residence in Baltimore: No. 1800 Thomas Ave St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March (Month) 16 (Day), 1830 (Year)

7-AGE, 87 yrs. 7 mos. 20 ds.

If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bavaria

PARENTS.

10-NAME OF FATHER, John Horner

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Barbara Horner

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Silver

(Address) 1800 Thomas Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 1 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1917, to Dec 1917, that I saw h alive on Dec 1917, and that death occurred, on the date stated above, at 8.15 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 5, 1917. (Address) 4444 Augusta Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 7 1917

20-UNDERTAKER [illegible]

ADDRESS 14 Fetterman 2433 N Howard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 7 - 1917 BOARD OF Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D10656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10656

130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 E. Oliver ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Lang.

(Residence in Baltimore: No. 2324 E. Oliver St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, December 25, 1848 (Month) (Day) (Year)

7-AGE, 68 yrs. 11 mos. 9 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Retired 20 25 00

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mae O. Forster

(Address) 2324 E. Oliver st

15-

Filed ....., 191.....

Registrar.

ROBERT B. KRAUSE
DEC 7 1917
Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 4, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1912, to Dec 4 1917, that I saw him alive on Dec 4 1917, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

High Blood Pressure
Chronic Interstitial Nephritis
Apoplexy
(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Duration
(Duration) ..... yrs. ..... mos. 2 6 ds.

(Signed) Ernest C. Williams M. D.

Dec 6, 1917. (Address) 1719 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Emmanuel Cemetery — DATE OF BURIAL, December 7, 1917

20-UNDERTAKER Christian Miller — ADDRESS 2334 E. Oliver st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10657

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Tilest ST.; 1 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Stansbury

(Residence in Baltimore: No. 2311 Tilest St.; 4 yrs., 4 mos. ds.)

WRITE PLAINLY, with ordinary pen and ink. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, August (Month), 1913 (Year)

7-AGE, 4 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Stansbury

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Annie Reynolds

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Stansbury

(Address) 2712 Dillon St

15-

Filed....., 191.....

Registrar.

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1917, to Dec 6th, 1917, that I saw h- alive on Dec 6th 1917, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) none

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. Thornton M. D.

Dec 6, 191.. (Address) 1 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	Dec 7, 1917
20-UNDERTAKER	ADDRESS
Lilly & Geier	403 N. Mayfield

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10658 40 D10658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3128 Eastern Ave. ST.; 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Hanratty.

(Residence in Baltimore: No. 3123 Eastern ave St.; 71 yrs., 1 mos. 12 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 25th, 1846 (Month) (Day) (Year)

7-AGE, 71 yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... 600 600

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER. Thomas Hanratty.

11-BIRTHPLACE OF FATHER (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER Bridgit Grant.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Hanratty.

(Address) 3123 Eastern Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 6 1917, that I saw him alive on Dec 6 1917, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Primary

(Duration)....yrs. 6 mos.....ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration)....yrs.....mos. 7 ds.

(Signed) Wm. H. McCaw M. D.

Dec 6, 191.7. (Address) 839 S. Elwood.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Dec. 10th, 1917.

20-UNDERTAKER Lilly & Feiler.

ADDRESS 422 N. Howard St.

W 3069

Spec.—8-24-14—M. & T.—2000 Bks.

D10659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130 D10659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Henderson Ln ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F Weber

(Residence in Baltimore: No. 400 Henderson Ln St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Aug (Month) 2 (Day) 1864 (Year)

7-AGE.	If LESS than 1 day,
53 yrs. 4 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Florian Weber

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Maximanda Schafer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alex. N. Bradly

(Address) 400 Henderson St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1917, to Dec 5th 1917, that I saw h— alive on Dec 5th 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ? yrs. mos. ds.

(Signed) Thomas Stroud M.D.

....., 191... (Address) 753 Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bon Secours | DATE OF BURIAL, Dec. 8, 191.

20-UNDERTAKER E. A. Wiedefeld Jr. | ADDRESS Fremont Ave

DEC 7 1917 ROBERT R. KRAUTER BURIAL PERMIT Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10660 HEALTH DEPARTMENT—CITY OF BALTIMORE D10660

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospt ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Stickley

(Residence in Baltimore: No. 816 W. Lexington St St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Aug (Month) ..... — (Day), 1917 (Year)

7-AGE, — yrs. 5 mos. — ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, R. Stickley

11-BIRTHPLACE OF FATHER (State or Country), unknown.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Stickley

(Address) 816 W. Lexington St

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 7 1917, and that death occurred, on the date stated above, at 12 am.

The CAUSE OF DEATH* was as follows:

Acute Mic. Colitis.

.....

.....

..... (Duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. B. Brumbaugh M. D.

12-7..., 1917. (Address) Univ Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 5 ds. In the State ..... yrs. Life mos. ..... ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 816 W. Lexington St

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemy — DATE OF BURIAL, Dec 8, 1917.

20-UNDERTAKER Willard E Fuller — ADDRESS 221 N Broadway

D10661 HEALTH DEPARTMENT—CITY OF BALTIMORE D10661

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1546 N. Fremont St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dickson

(Residence in Baltimore: No. 1546 N. Fremont St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... September, 18..... (Month) (Day) (Year)

7-AGE, Unknown ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Keeper

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), U

12-MAIDEN NAME OF MOTHER U

13-BIRTHPLACE OF MOTHER (State or Country), U

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... James Smith

(Address) 1546 N. Fremont

15-

Filed....., 191.....

Registrar.

ROBERT B. KRAUSER
Registrar of Vital Statistics
DEC 7 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December 5th ....., 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis
2 .....
3 .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Dec. 6, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec. 7, 1917

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 W. Lanvale

D10662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D10662

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 814 Peach Alley. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Dunbar.(C)

(Residence in Baltimore: No. 814 Peach Alley. St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know. (Month), / (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 40

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9-BIRTHPLACE, (State or Country), Florida.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Martha Edwards.(C)
(Informant).....
(Address) 814 Peach Alley.

15-
Filed....., 191...
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th. 1917. (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner)
Dec, 6th. 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 7 1917
20-UNDERTAKER	ADDRESS
L. V. Draughon	118 N. Howard St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10663 D10663 92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin & Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 100 Calhoun ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie Williamson

(Residence in Baltimore: No. 1912 1914 W Franklin St.; Life time nos.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Aug 30th, 1871 (Month) (Day) (Year)

7-AGE, 46 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, J H Wickes

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Cole

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Wm C Williamson

(Address) 1912 W Franklin St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 5 1917, that I saw her alive on Dec 5 1917, and that death occurred, on the date stated above, at 5-35 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Rowland Kretzer M. D.

Dec 5, 1917. (Address) Franklin & Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1912 W Franklin St

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 7, 1917

20-UNDERTAKER Geo A Gerber

ADDRESS Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10661

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. W. P. Infirmary St.: 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna J. McTeague

(Residence in Baltimore: No. 1011 N. Lafayette Ave St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1915 (Year)

7-AGE, 2 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, James McTeague

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Coan (Corr.)

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1011 N Lafayette Ave

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns
Shock
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gross Carelessness

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Dec. 7, 1917

20-UNDERTAKER Martin Fahey & Sons | ADDRESS 1 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10665

1-PLACE OF DEATH St. Vincent's Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division ST.: 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Anthony White

(Residence in Baltimore: No. 1401 Division St.: yrs. 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wh.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 5-94 (Day), 1917. (Year)

7-AGE, yrs. 10 mos. 18 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None yo
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Elizabeth Burroughs

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sis. Vincents

(Address) 1401 Division St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5-94 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1917, to Dec 5-94 1917, that I saw h[illegible] alive on Dec, 4-94 1917., and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Diarrhea Infantum

Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leona M.C. Carter M. D.

, 191... (Address) 525 N. Duke St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 10 mos. 18 ds. In the State yrs. 10 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral

DATE OF BURIAL, Dec 7, 1917.

20-UNDERTAKER Martin Fahey & Son

ADDRESS 602 W. Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37V

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Little

(Residence in Baltimore: No. 1624 Division St.; 44 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1877 (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ..... mos. ..... ds.	....hrs. or....mIn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hotel

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm H. Little

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co

12-MAIDEN NAME OF MOTHER Malinda Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Little

(Address) 1624 Division St

15-

Filed....., 191.....

Registrar.

Md. 5663

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25th 1917 to Dec 6th 1917, that I saw him alive on Dec 5th 1917, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrh
(Mitral)

(Duration) 3 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Edward Gradwohl M. D.

Dec 6th, 1917. (Address) 627 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Dec 8 1917

20-UNDERTAKER	ADDRESS
Jno A. Burkhardt	1517 W. Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D10667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D10667

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Jefferson

(Residence in Baltimore: No. 725 George St.: 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1883 (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Chase

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Maggie

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 110 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7th 1917, to Dec 5th 1917, that I saw her alive on Dec 5 1917, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Disciol M. D.

Dec 6th, 191.7. (Address) 607 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec 8 191...

20-UNDERTAKER John T. Bishop — ADDRESS 1107 Druid Hill Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10668

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10668

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 7 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Israel Isaacs

(Residence in Baltimore: No. 2143 Eager St.; 5 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, ... 32 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Worked at
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Harrison Bros

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... J. Lewis

(Address) ..... 141 E Baltimore

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 7 ....., 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1917, to Dec 7 1917, that I saw him alive on Dec 7 1917, and that death occurred, on the date stated above, at 8.00 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral stenosis + insufficiency

.....

..... (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY. Hypostatic
(Secondary)
pneumonia (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... Edward Barton M. D.

Dec 7, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 47 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2143 Eager St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Hebrew Rest — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Fuch Lewis — ADDRESS 141 E Balt

Dec 7, 1917 — Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

D10669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10669

CERTIFICATE OF DEATH.

105

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 S. Charles ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Harvey

(Residence in Baltimore: No. 502 S. Charles st, St. 12 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month), 1 (Day), ... (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(h) General nature of industry, business, or establishment in which employed (or employer): Pt. Comfort

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, William Harvey

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Evans

(Address) 502 S. Charles St.

15-

Filed ....., 191....

Registrar.

DEC 7 - 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14 1917, to Dec. 3, 1917, that I saw her alive on Dec 3, 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Primary Gastro Enteritis

Immediate Exhaustion

(Duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. 19 ds.

(Signed) L. P. Brown M. D.

Dec 7, 1917, (Address) 502 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chapel Hill N. Co. DATE OF BURIAL, Dec 7, 1917

20-UNDERTAKER Brown & Friedland ADDRESS 1140 N. Schroeder St.

D10670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D10670

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1731 Maryland ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Lewis

(Residence in Baltimore: No. 1731 Maryland 9 St.; yrs., 10 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Jno Hill

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lucie Hill

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vernum Lewis

(Address) 1731 Maryland

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastritis

Don't know Cause- may have been Gastritis or Appendicitis

24 hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W S Ruby (Coroner.) M. D.

Dec 7, 1917 (Address) 1639 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Norfolk. Va | DATE OF BURIAL, Dec 8, 1917

20-UNDERTAKER Samuel T Hemsley | ADDRESS 578 W Biddle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D10671

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 835 Hollins St.: 18 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hiram H. Condrey

(Residence in Baltimore: No. 835 Hollins St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Don't know (Month) (Day), 1890 (Year)

7-AGE, about 27 yrs. mos. ds. If LESS than 1 day, hrs. or mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Cook

(Address) Greenmount & North Ave

15-

DEC 7 - 1917

Filed ....., 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning
Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. D. Driscoll M. D.
(Coroner.)

Dec 7, 1917. (Address) 1211 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Atlanta - Ga	Dec 7, 1917
20-UNDERTAKER Wm. Cook	ADDRESS 502 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10672

REGISTERED NO. C

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. 14 ST.; WARD)

2-FULL NAME Infant Child of Captain J.C. Foster & Mary W. Foster

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Womans Hospital St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, Dec 6 1917 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 25 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Captain John Plunket Foster

11-BIRTHPLACE OF FATHER (State or Country), Iowa

12-MAIDEN NAME OF MOTHER Mary Wales

13-BIRTHPLACE OF MOTHER (State or Country), Norfolk – Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. H. Wales

(Address) 1400 Colonial Ave Norfolk Va

15-

Filed Dec 7, 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1917 (Month) (Day) (Year)

17-. I HEREBY CERTIFY, That I attended deceased from 25 minutes 191 , to 191 ,

that I saw h im alive on Dec 6 191 7 ,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... yrs. 25 min mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Dwight Barnhart M. D.

Dec 6, 1917. (Address) Womans Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 25 min mos. ..... ds. In the State 25 min yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Norfolk Va

DATE OF BURIAL, 12 6, 1917

20-UNDERTAKER Henry McJenkins & Sons Co

ADDRESS Richard & McCulloh Sts

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10673

CERTIFICATE OF DEATH.

152 D10673

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Wyeth ; ST.; 21 WARD)

2-FULL NAME Harry Sleg. Floyd -

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 504 Wyeth St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. ..... (Month) ..... (Day) 1917 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 6. mos. .....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, H. J. Floyd.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Lillian Chase

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE ~~BEST~~ OF MY KNOWLEDGE.

(Informant) Harry Floyd

(Address) 504 Wyeth St.

15-

Filed....., 191.....

Registrar.

DEC 7 - 1917 ROBERT R. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1917, to Dec. 6 1917, that I saw h[illegible] alive on Dec 6 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

12-7, 1917 (Address) 682 Columbia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westview Cemetery

DATE OF BURIAL, Dec 7th, 1917

20-UNDERTAKER Geo Lumbrecht

ADDRESS 6471 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D10674

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D10671

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 W. North Ave. 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Wiesner

(Residence in Baltimore: No. 1335 W. North Ave St.; 14 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Feb (Month) – 16 (Day) –, 1844 (Year)

7-AGE, 73 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or kind of work..... Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Europe. Germany

PARENTS.

10-NAME OF FATHER, Louis

11-BIRTHPLACE OF FATHER (State or Country), Europe. Germany

12-MAIDEN NAME OF MOTHER Victoria Schwab

13-BIRTHPLACE OF MOTHER (State or Country), Europe Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Anna Smith

(Address)..... 1335 W. North Ave

15-

Filed....., 191.....

DEC 7 - 1917 ROBERT R. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 6 1917, that I saw her alive on Dec 6 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

.....

Cerebral Hemorrhage

..... (Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... F. C. Zeik M. D.

Dec 6, 191 7 (Address) 1313 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Dec. 8, 191 7
20-UNDERTAKER	**ADDRESS**
Louis Heermann	32 S Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Samuel S. Baley.

D10675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10675

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John St. Hopkins Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel S. Baley

(Residence in Baltimore: No. 1517 John St. Balto. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. ? ? 1878
(Month) (Day) (Year)

7-AGE. 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Grocer

9-BIRTHPLACE. (State or Country). Balto. Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Ruth

(Address) John St. & Rivard Ave. Balto

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 6, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1917, to Dec 6 1917, that I saw him alive on Dec 6 1917, and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma Kidney

Duration Several

CONTRIBUTORY (Secondary) Perforation + infection of bowel into pericardial cavity

(Duration) yrs. mos. ds.

(Signed) W. H. Davis M. D.

Dec 7, 1917. (Address) John St. Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 1 mos. 3 ds. In the State 39 yrs. mos. ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence 1517 John St. Balto

19-PLACE OF BURIAL, OR REMOVAL. Montclair Baltimore Md. DATE OF BURIAL. Dec. 8, 1917.

20-UNDERTAKER Steuart & Nonnemacher ADDRESS 108 W. Mt. Royal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10676

CERTIFICATE OF DEATH.

120

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Madison Ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mallie O Bain

(Residence in Baltimore: No. 937 Madison Ave St.; 35 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE wh

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH. June 6, 1878 (Month) (Day) (Year)

7-AGE. 39 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 937

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Isaac Shipley

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ella Stoffolens

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Samuel A Bain

(Address) 937 Madison Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec. 6, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1917, to Dec 6 1917, that I saw h_ alive on Dec 5 1917, and that death occurred, on the date stated above, at 5½ P. m.

The CAUSE OF DEATH* was as follows: Chronic Bronchial disease

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs....mos....ds.

(Signed) R B Stauffer M. D.

Dec 7, 191... (Address) 730 Park Ave

DEC 7 - 1917 ROBERT B. STAUFFER

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Dec 8, 191.

20-UNDERTAKER Mrs A Kohde Son

ADDRESS 730 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10672

HEALTH DEPARTMENT—CITY OF BALTIMORE

108 D10672

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary T. Whitney

(Residence in Baltimore: No. 3502 Old York Road St.; ...yrs., ...mos. ...ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) Don't Know (Day) 1890 (Year)

7-AGE, 27 yrs. 4 mos. Don't Know ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 037
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Duschek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Sofia

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rec'd Mercy Hosp

(Address) Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Dec 7 1917, that I saw her alive on Dec 7 1917, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas
Appendix
(Duration) abt 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Peritonitis
(Duration) abt yrs. mos. 14 ds.

(Signed) Edward H. Smith M. D.

Dec 7, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 13 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? 3502 Old York Rd

Former or usual residence 3502 Old York Road

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 10, 1917.

20-UNDERTAKER Wm Cook — ADDRESS 502 E Mt

DEC 7-1917 ROBERT E. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10678

CERTIFICATE OF DEATH.

61 D10678

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Elwood Place ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia D. Gail

(Residence in Baltimore: No. 1907 Elwood Place St.; 1 yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	[illegible]

6-DATE OF BIRTH, Jan (Month) 6 (Day), 1916 (Year)

7-AGE, 1 yrs. 11 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William Gail

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mable Nickel

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas W. Nickel Jr

(Address) 1907 Elwood place

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 7 1917, that I saw her alive on Dec 6 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(a) Pneumococcus Meningitis

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ... yrs. 1 mos. ... ds.

(Signed) Elmer G. Hall M. D.

Dec 7, 1917. (Address) 1611 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, 12/9, 1917.

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10679 HEALTH DEPARTMENT—CITY OF BALTIMORE D10679

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 763 W. Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mercetta Taylor

(Residence in Baltimore: No. 763 W. Franklin St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Col	S

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 3 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, Clarence Taylor

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER Francis Green

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Taylor

(Address) 763 W. Franklin

15-

Filed....., 191.....
Registrar.

ROBERT L. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 6 1917, and that death occurred, on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. 5 mos. 7 ds.

(Signed) Jno. G. Clark M. D.

Dec 7, 1917 (Address) 2416 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Dec 8, 1917
20-UNDERTAKER	ADDRESS
Charles B. Jones	235 Pine

Spec.—8-24-14—M. & T.—2000 Blks.

D10680 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10680

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Clifton Av. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Dettmer

(Residence in Baltimore: No. 2016 Clifton Ave. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	white.	Married

6-DATE OF BIRTH, June (Month) 29 (Day), 1853 (Year)

7-AGE, 64 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Columbus Dettmer.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth P. Dettmer

(Address) 2016 Clifton ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Dec 7th 1917, that I saw him alive on Dec 6th 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration).....yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

..... (Duration).....yrs.....mos. 1 ds.

(Signed).....M. D.

Dec 8th, 191.7 (Address) W. Fayette Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Dec. 10, 191.7

20-UNDERTAKER Wm Cook. ADDRESS 502 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10681

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10681

1 PLACE OF DEATH 21

REGISTERED No. C 151

CITY OF BALTIMORE: (No. 2017 N. Fulton Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Marie McConnell

(Residence in Baltimore: No. 2017 N. Fulton Ave St.; yrs. mos. 18 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the Word): Single

6-DATE OF BIRTH: November (Month) 20 (Day), 1917 (Year)

7-AGE: yrs. mos. 18 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Wm S. McConnell

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Lillian Storns

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm S. McConnell

(Address) 2017 N. Fulton Ave

15-

Filed DEC 8 - 1917, 191 ROBERT R. ROSS Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) - 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov-20, 1917, to, Dec-7-1917, that I saw h[illegible] alive on Dec-7 1917, and that death occurred, on the date stated above, at 6-30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Month
6 Mos. Utero-Gestation

(Duration) yrs mos ds.

Contributory (SECONDARY) Inanition

(Duration) yrs mos ds.

(Signed) Chas Jones M. D.

12-8-, 191 7 (Address) 2802 Roslyn Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Westernview Cemetery

DATE OF BURIAL: Dec 8, 1917

20-UNDERTAKER: Josiah Eyler

ADDRESS: 16 W Madison

Spec.—8-24-14—M. & T.—2000 Bks.

D10682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10682

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Mary Keller.

(Residence in Baltimore: No. 1312 N. Central Ave. St.; yrs., mos. ds.)

Life

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, July 28 (Month) (Day), 1871 (Year)

7-AGE. 46 yrs. 4 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas Keyl

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Dorothea Kuhn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bradley M. Keller

(Address) 1312 N. Central Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1917, to Dec. 7, 1917, that I saw h[illegible] alive on Dec. 6, 1917, and that death occurred, on the date stated above, at 7.45 Am.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) dont know yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) J. Edward Norris M. D.

12/7/17, 191.. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? dont know

Former or usual residence 1312 N. Central Avenue.

19-PLACE OF BURIAL OR REMOVAL, Holy Cadeum DATE OF BURIAL, Dec 10, 191..

20-UNDERTAKER Robt Jones ADDRESS 1742 Y Mary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10683 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **D10683**

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1622 N. Bradford ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen R Coombs

(Residence in Baltimore: No. 1622 N. Bradford St.: ...yrs.. ...mos. ...ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH Oct 30, 1876 (Month) (Day) (Year)

7-AGE 41 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Jno. W. Coombs

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Jenny Brent

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Coombs

(Address) 2220 Monument St

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 191 7, to Dec 5 191 7, that I saw h[im] alive on Dec 5 191 7, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

8

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Tubercular Meningitis

(Duration) ...yrs. ...mos. ...ds.

(Signed) Edward Lewis M. D.

Dec 7, 191 7 (Address) 913 N Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cremation — DATE OF BURIAL, Dec 8, 191 7

20-UNDERTAKER Chas Shaw — ADDRESS 1424 Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10681

D10681

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Argyle Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisa J Nicholson

(Residence in Baltimore: No. 1211 Argyle Ave St.; 75 yrs., 5 mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July — (Month) (Day), 1842 (Year)

7-AGE, 75 yrs. 5 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Servant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Richard Tibbs

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Tibbs

(Address) 1211 Argyle Ave

15-

Filed....., 191.....

Registrar.

ROBERT B. KRAUTER
DEC 8 - 1917
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 18 1917, to Dec 6th 1917, that I saw her alive on Dec 5th 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

C. D. (Duration) — yrs. — mos. 10 ds.

(Signed) Marcus C Williamson M. D.

Dec 8, 191.. (Address) 1327 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Dec 8, 191.7

20-UNDERTAKER Samuel J Hemsley

ADDRESS 578 W Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10685

CERTIFICATE OF DEATH.

D10685

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie McCallum

(Residence in Baltimore: No. 12th & North Av. St.: 40 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 15 (Day), 1883 (Year)

7-AGE, 34 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, W. Bryant Tunlington

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Ella J. Bassett

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. B. Tunlington

(Address) 12th & North Av.

15-

Filed....., 191...

Registrar.

ROBERT R. KRAUTER
DEC 8 - 1917
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 1917, to Dec 7 1917, that I saw her alive on Dec 7 1917, and that death occurred, on the date stated above, at 9 40 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward H. Smith M. D.

, 191... (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? North Av.

Former or usual residence North Av.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Dec. 10, 1917

20-UNDERTAKER Geo. W. Little

ADDRESS 531 N. Fremont Av.

Spec.—8-24-14—M. & T.—2000 Bks.

D10686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred H. McBride

(Residence in Baltimore: No. none (Santa Fe, N.M.) St.; — yrs., 7 mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Freight Agent
(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

9-BIRTHPLACE, (State or Country), Iowa

PARENTS.

10-NAME OF FATHER, Samuel S. McBride

11-BIRTHPLACE OF FATHER (State or Country), Iowa

12-MAIDEN NAME OF MOTHER Ella Bassett

13-BIRTHPLACE OF MOTHER (State or Country), Iowa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. McBride

(Address) Santa Fe, N.M.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 7 1917, that I saw him alive on Dec 7 1917, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows: Sarcoma of lungs.

..... (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

..... (Duration) yrs. mos. 6 ds.

(Signed) E.H. Teeter M. D.

Dec 7, 191.7. (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Santa Fe, N.M.

Former or usual residence Santa Fe N.M.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Santa Fe, New Mexico	Dec. 8, 191.7.

20-UNDERTAKER	ADDRESS
Geo W Little	531 N. Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10687.

66

D10687.

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 E. Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmira F. Gaw

(Residence in Baltimore: No. 1914 E. Federal St.; 5 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec 25, 1832 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
84 yrs. 11 mos. 12 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, John T. Daw

11-BIRTHPLACE OF FATHER (State or Country), Virg.

12-MAIDEN NAME OF MOTHER Samara Hyde

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Hemberger

(Address) 1914 E. Federal St

15-

Filed....., 191.....

DEC 8-1917 ROBERT B. KRAUTER Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1917, to Dec 7 1917, that I saw h w alive on Dec 6 1917, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis

.....

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Fussler M. D.

Dec 8, 1917 (Address) 1823 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Chester Pa	Dec 9....., 1917.
20-UNDERTAKER	ADDRESS
Wm. Cook	502 E. North

D10688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10688

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 201 n Paca St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam E. Smith

(Residence in Baltimore: No. 201 n Paca St.; 45 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, July 8, 1872
(Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk in
(b) General nature of industry, business, or establishment in which employed (or employer): Hospitals

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marion Smith

(Address) 201 n Paca

15-

Filed ..... 191...

Registrar.

ROBERT B. KRAUTER
DEC 8-1917
Registrar Board of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Muth Coroner M.D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Dec 8 1917

20-UNDERTAKER Christian Miller — ADDRESS 2384 Jefferson st

D10689

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10689

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2915 N. Calvert St. WARD 12)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Harvey

(Residence in Baltimore: No 2915 N. Calvert St.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: March 25, 1887 (Month) (Day) (Year)

7-AGE: 30 yrs. 8 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10-NAME OF FATHER: James W. Mahon

11-BIRTHPLACE OF FATHER (State or country): Balto., Md

12-MAIDEN NAME OF MOTHER: Ella Mahon

13-BIRTHPLACE OF MOTHER (State or country): Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Rita Dunn

(Address) 2915 N. Calvert St.

15

Filed ....., 191.... REGISTRAR

DEC 8 - 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 7, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1917 to Dec. 7th 1917, that I saw h~~er~~ alive on Dec. 7th 1917, and that death occurred, on the date stated above, at 9:40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hot Nurse- (Duration) ..... yrs. ..... mos. ..... ds

Contributory Hernia (SECONDARY)

..... (Duration) — yrs. — mos. 26 ds.

(Signed) Frederick L. Cotton M. D.

Dec 8th, 1917 (Address) 2927 N. Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Catholic Cemetery — DATE OF BURIAL: 12/10/17

20-UNDERTAKER: Henry W. Meash & Son — ADDRESS: 1625 N. Calvert St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10690

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 ✓ D10690

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No 2634 North Charles St. 26th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Bridget Jordan

(Residence in Baltimore: No. 2634 North Charles St.: 96 yrs. 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH: July 10th, 1821 (Month) (Day) (Year)

7 AGE: 96 yrs. 4 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9 BIRTHPLACE (State or country): County Wexford, Island

PARENTS

10 NAME OF FATHER: James Hanrahan,

11 BIRTHPLACE OF FATHER (State or country): County Wexford, Island

12 MAIDEN NAME OF MOTHER: Mary Carroll,

13 BIRTHPLACE OF MOTHER (State or country): County Wexford, Island

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daughter {Mrs. E. J. Chasety / Mrs. T. Hearn}

(Address) 2634 N. Charles St.

15

Filed ....., 191.... ROBERT R. KRAUTER DEC 8 - 1917 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 7th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 11th, 1917. to. December 7th 1917. that I saw h[illegible] alive on December 7th. 1917. and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ? yrs. ? mos. ? ds

Contributory (SECONDARY) Edema of Lungs (Probably)

(Duration) ? yrs. ? mos. ? ds.

(Signed) William Garth Clopton M. D.

December 7th, 1917 (Address) 2919 Huntingdon Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/10 ....., 1917

20 UNDERTAKER: Henry H. Mears & Son — ADDRESS: 805 W. Gaherty St.

D10691

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10691

1 PLACE OF DEATH

REGISTERED No. C 170

CITY OF BALTIMORE: (No. 2023 Keyser ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Coleman

(Residence in Baltimore: No. 2028 Keyser St.; 41 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June 10, 1876 (Month) (Day) (Year)

7-AGE: 41 yrs. 5 mos. 24 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Jhon Denby

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane. Denby

(Address) 2023. Keyser St

15- Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 4th 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15th, 1917, to, Dec. 4th 1917, that I saw h[illegible] alive on Dec 3d 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

0730

(Duration) — yrs 4 mos. 17 ds.

Contributory (SECONDARY) .....

(Duration) — yrs — mos. — ds.

(Signed), John Davis, M. D.

Dec 7 1917 [Address] 2023 Orleans St

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel cemtery — DATE OF BURIAL: Dec 8 1917

20-UNDERTAKER: Milton. Davis — ADDRESS: 413 N Eden St

DEC 8 - 1917 ROBERT B. KRAUTER Registrar of Wills

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10692

D10692

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Greenmount Ave WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Graves

(Residence in Baltimore: No. 2202 Greenmount Ave St.; ...yrs., mos. ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, ..., 1847
(Month) (Day) (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Peter Duffy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary J Christie

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Green

(Address) 2202 Greenmount Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5 191 7, to June 7 191 7, that I saw h[illegible] alive on June 6 191 7, and that death occurred, on the date stated above, at 7:[illegible] m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cerebral Thrombosis

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Harvey Boyd M. D.

June 8, 191 7 (Address) 602 Columbus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Dec. 10., 1917.

20-UNDERTAKER Martin Fahey & Son — ADDRESS 606 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10693

CERTIFICATE OF DEATH.

D10693

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Kamm

(Residence in Baltimore: No. Mercy Hospital St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... Sept Kamm ....., 1 .....
(Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer) ..... Tailor 086

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hosp

(Address) Mercy Hosp

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1917, to Dec 5 1917, that I saw him alive on Dec 5 1917, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

D
Pulmonary Tuberculosis
(Duration) 2 mos. Not known

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Smith M. D.
Dec 5, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 22 ds. In the State yrs. 7 mos. ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence Not known

18-PLACE OF BURIAL OR REMOVAL, Schwartz Cemetery — DATE OF BURIAL, Dec 7, 191...

20-UNDERTAKER Robt S. Gurney — ADDRESS 1942 N. Broad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10694 D10694

CERTIFICATE OF DEATH.

+175

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. John Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Neal Lane

(Residence in Baltimore: No. 2 mos & 8 days) Denton Md St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, June 18, 910
(Month) (Day) (Year)

7-AGE, 7 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Boy
(b) General nature of industry, business, or establishment in which employed (or employer). do

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, W J Lane

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Lane

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W J Lane

(Address) Hopkins Hosp

15-

Filed DEC 8 1917, 191.

ROBERT B. KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, left lung
cavity noted at operation,
Arteriosclerosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Dec 8, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. mos. 8 ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Denton Md

DATE OF BURIAL, Dec 8, 1917

20-UNDERTAKER Albert E. Fuller

ADDRESS 221 N. Edwards

Spec.—8-24-14—M. & T.—2000 Bks.

D10695 HEALTH DEPARTMENT—CITY OF BALTIMORE 164 D10695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 137 W. West st. St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Jackson

(Residence in Baltimore: No. 137 W. West st St.; 27 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Oct. 6th (Month) (Day) 1867 (Year)

7-AGE, 50 yrs. x mos. x ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Steamboat Co.

9-BIRTHPLACE, (State or Country), Calvert Co. Maryland

PARENTS.

10-NAME OF FATHER, Wm H. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Maryland

12-MAIDEN NAME OF MOTHER Nancy Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allie Jackson

(Address) 407 W. Pawlins st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 6th (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 6, 1917, that I saw him alive on Dec. 6, 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Primary — Pleuro pneumonia Lobar

Immediate Exhaustion

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. S. Young M. D.

Dec 8, 191.. (Address) 506 Hanover st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PERKINS HOSPITAL — DATE OF BURIAL, Dec 8 191..

20-UNDERTAKER Commissioner Health — ADDRESS 578 W. Biddle St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10693 HEALTH DEPARTMENT—CITY OF BALTIMORE D10696

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Adelaide Jackson

(Residence in Baltimore: No. 2421 Lakeview Ave St.; 37 yrs., mos. ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 20 (Day), 1864 (Year)

7-AGE, 53 yrs. 11 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Boston Mass

PARENTS.

10-NAME OF FATHER, Wolf Jackson

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eliza Abrams

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Jackson

(Address) Boston Mass

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 8 1917, that I saw her alive on Dec 8 1917, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Carcinoma of Bladder

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 1 ds.

(Signed) B Jacobson M. D.

Dec 8, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Total Admission

19-PLACE OF BURIAL OR REMOVAL, Boston Mass

DATE OF BURIAL, Dec 8, 1917.

20-UNDERTAKER Van Sondern

ADDRESS 110 N Ayres

Spec.—8-24-14—M. & T.—2000 Bks.

D10697 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10697

151

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cohen

(Residence in Baltimore: No. 1203 S. Caroline St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Dec. 6, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.
If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Isaac Cohen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca Plut

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I. Cohen

(Address) 203 S. Caroline St

15-

Filed ....., 191.....

Registrar.

DEC 9- 1917 ROGER B. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6 1917, to Dec. 7 1917, that I saw him alive on Dec. 7 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Aspiration Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

8 — hrs before (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. Jacobson M. D.

Dec. 9, 1917 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Henning Run — DATE OF BURIAL, Dec. 9, 1917.

20-UNDERTAKER S. Weinstein Bro — ADDRESS 1104 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully and fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10698 HEALTH DEPARTMENT--CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH

14 2 D10698

REGISTERED No. C

CITY OF BALTIMORE (No. 1816 E Fayette St.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Amoss

(Residence in Baltimore: No. 1816 E Fayette St.: 23 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Unknown (Month) , 1 (Day) (Year)

7-AGE: 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 68

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Abraham Amoss

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Amoss.

(Address) 1816 E Fayette St

15-Filed DEC 9 - 1917 , 191 ROBERT R. CRATER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec (Month) 6 (Day) , 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1914, to Dec 6 1917 that I saw him alive on Dec 6, 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Raynauds disease,
Mitral stenosis,
Aortic stenosis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Dilated Heart.

(Duration) yrs. 4 mos. ds.

(Signed) M. Theodoral M. D.

, 191 (Address) 216 N. High St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1816 E Fayette St

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: Dec 7, 1917

20-UNDERTAKER: Max Levinson — ADDRESS: 1107 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 + 184 ✓ D10699

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 Melrose Alley ST.; ✓ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Loudenslagen

(Residence in Baltimore: No. Arlington, Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October 13, 1874
(Month) (Day) (Year)

7-AGE, 43 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman ✓
(b) General nature of industry, business, or establishment in which employed (or employer): 34

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Wm. Loudenslagen

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER: Margaret Martin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine E. Loudenslagen

(Address) 4 Lewiston Ave

15-

Filed ....., 191.....

ROBERT R. KRAUTER
DEC 7 1917
DEPUTY REGISTRAR

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull Caused by being Struck in head with Stone Homicide

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) C. E. Truscott M. D.
(Coroner.)

Dec 6, 1917. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Wards Chapel

DATE OF BURIAL, Dec. 7, 1917

20-UNDERTAKER William Cook

ADDRESS 502 E. North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

D10700

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2643 Greenmount St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie E nee Leary

(Residence in Baltimore: No. 2643 Greenmount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	wht	Married

6-DATE OF BIRTH, ... Jan 16 ....., 1860
(Month) (Day) (Year)

7-AGE, ..57.. yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Wisner

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary E Spear

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Coggan

(Address) 2633 Greenmount

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 6 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pneumonia 7 days.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cem	Dec 10..., 19.17
20-UNDERTAKER Wm. Cook	ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1070T

D1070T

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Sanatorium

CITY OF BALTIMORE: (No. 1518 Eutaw Place St.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. David Levy.

(Residence in Baltimore: No. 1418 Eutaw Place St.; ..... yrs., 2 mos. 25 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... Jan. 1 ....., 1896
(Month) (Day) (Year)

7-AGE, 21 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Levy's

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Solomon Levy

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rebecca Abrams

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jack Lewis

(Address) ..... 1411 Eutaw St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 8th ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 13 1917, to Dec. 8 1917, that I saw h[illegible] alive on Dec. 8 1917, and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

General Melanosarcomatosis

Metastases to Spinal Cord

(Duration) ..... yrs. 4 mos. 25 ds.

CONTRIBUTORY (Secondary) Melanosarcoma of foot

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Elizabeth M. Moyer M. D.

Dec. 8, 1917 (Address) 1411 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. 25 ds. In the State ..... yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death? Suffolk Virginia

Former or usual residence Suffolk Virginia

19-PLACE OF BURIAL OR REMOVAL, Norfolk Va. DATE OF BURIAL, ..., 191...

20-UNDERTAKER Jack Lewis ADDRESS 1411 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10702

CERTIFICATE OF DEATH.

H3 D10702

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 E Fayette ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Eshman.

(Residence in Baltimore: No. 2002 E Fayette St.; 17 yrs. ..... mos. ..... ds.)

N.B.—THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) ..... (Day) 1874 (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Herbert

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Herbert

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March, 1916, to Dec 8th 1917, that I saw h.. alive on Dec 7th 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of Urinary bladder

..... (Duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D.

12 Feb 1918, (Address) 1 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Harleman circle — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

D10703

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D10703

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 W. Fayette ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Ebert

(Residence in Baltimore: No. 1715 W. Fayette St.; ..... yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Nov (Month) 14 (Day), 1836 (Year)

7-AGE: 81 yrs. 0 mos. 23 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: John Ebert

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar A. Ebert

(Address) 1715 W Fayette St

16-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6, 1917, to, Dec 7, 1917, that I saw h.. alive on Dec 7, 1917, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 6 mos. 6 hrs.

Contributory (SECONDARY) Arterio-Sclerosis

..... (Duration) 8 yrs. ..... mos. ..... ds.

(Signed) W. O'Neill M D

Dec. 8, 1917 [Address] 105 N Sutton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem Twp. DATE OF BURIAL: Dec 10th, 1917

20-UNDERTAKER: F. A Krause ADDRESS: 703 E Hoffman St

Spec.—8-24-14—[illegible] & T.—3000 lbs.

D10704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D10704

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N Bltimore ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Maria Cosety.

(Residence in Baltimore: No. 627 N Baltimore St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	W	Sngl

6-DATE OF BIRTH. April (Month) 12 (Day) 1917 (Year)

7-AGE,	If LESS than 1 day,
yrs. 7 mos. 26 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City -

PARENTS.

10-NAME OF FATHER, Henry Cosety -

11-BIRTHPLACE OF FATHER (State or Country), Italy -

12-MAIDEN NAME OF MOTHER Rosa Edenolfi.

13-BIRTHPLACE OF MOTHER (State or Country), Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Bruno

(Address) 226 S. Howard

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12- (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-3 1917, to 12-8 1917, that I saw h[illegible] alive on 12-7 1917, and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis in an institution - (St. Vincents)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition -

(Duration) yrs. mos. 15 ds.

(Signed) J. Bruno M. D.

12-8, 191.7 (Address) 1624 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent cemetery DATE OF BURIAL, [illegible], 191.7

20-UNDERTAKER John L Frahezer ADDRESS 1918 Lighter

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10705

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Fleet ST.; V WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Sletzer

(Residence in Baltimore: No. 1911 Fleet St.; 60 yrs., ... mos., ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, November, (Month) ....., 1 (Day) ..... (Year)

7-AGE, 81 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sletzer

(Address) 421 N. Minford Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1917, to Dec 4 1917, that I saw her alive on Dec 5 1917, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Arthritis (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. B. Mitton M. D.

Dec 8, 1917. (Address) 1711 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER Christian Miller ADDRESS 2334 Jefferson st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10706 HEALTH DEPARTMENT—CITY OF BALTIMORE

154 D10706

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 711 Park St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Davis

(Residence in Baltimore: No. 711 Park St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. Wilson

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Lammers

(Address) 1240 Bradford

15-

Filed....., 191.....

Registrar.

DEC 9 - 1912

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner.)

Dec 7, 191.. (Address)..

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Dec. 9, 191..
20-UNDERTAKER	ADDRESS
Christian Fuchs	[illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10707.

CERTIFICATE OF DEATH.

D10707.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Fleet ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chelsea Korpzi

(Residence in Baltimore: No. 2118 Fleet St ST.; 1 yrs., 7 mos. 10 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 1 (Day), 1910 (Year)

7-AGE, 1 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " 60

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Anthony Korpzi

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Helen Mishiwalky

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Korpzi

(Address) 2118 Fleet St

15-

Filed....., 191.....

Registrar.

DEC 9 - 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1917, to Dec 8 1917, that I saw h alive on Dec 7 1917, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

(Signed) A Tice M. D.

Dec 8, 1917. (Address) 2441 8th Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Dec 9, 1917
20-UNDERTAKER	**ADDRESS**
Jacob Jackson & Co	1428 S. Bond

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10708

CERTIFICATE OF DEATH.

17 D10708

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C

CITY OF BALTIMORE: (No. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Sauer

(Residence in Baltimore: No. Little Sisters of the Poor St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb 2 —, 1834
(Month) (Day) (Year)

7-AGE, 83 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Tekelman

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 191 , to 191 , that I saw her alive on Nov 25 191 7, and that death occurred, on the date stated above, at 2 p a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Nephritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. mos. ds.

(Signed) J. A. Warner M. D.

Dec 22, 191 7 (Address) 1123 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 6 yrs. 10 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER H. C. Friedfeld ADDRESS 1119 Druid Park Dr

DEC 5 - 1917 ROBERT D. CRAWFORD REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10709

D10709

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Homewood Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Edward Brown

(Residence in Baltimore: No. 1321 Homewood Ave. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ...January 3...., 1877
(Month) (Day) (Year)

7-AGE, 40 yrs. 6 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Robert J Brown

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Annie Grady

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary A. Shuham

(Address) 1321 Homewood Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Dec 5 1917, that I saw h alive on Dec 5 1917, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Bernard Wise M. D.

12-8, 191.. (Address) 5445 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Dec. 10, 1917

20-UNDERTAKER H. C. Wiedefeld — ADDRESS 847 Greenmt. Av.

Dr. Wise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10710 D10710

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 W. Clement ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Foley

(Residence in Baltimore: No. 114 W. Clement St.; 41 yrs., 10 mos. 9 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Jan 27, 1876. (Month) (Day) (Year)

7-AGE, 41 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Sheet Metal Works

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Michael Foley

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Gallagher

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha M. Gallagher

(Address) 114 W. Clement St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7. (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1917, to Dec 7 1917, that I saw him alive on Dec 6 1917, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

(Signed) J. M. Lemmon M. D.

Dec 7, 191 7. (Address) 826 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, 12/10, 191 7

20-UNDERTAKER M. J. Flynn

ADDRESS 1121 Light

Spec.—8-24-14—M. & T.—2000 Bks.

D10711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 E Clement St.; 24 WARD) REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Rubeach

(Residence in Baltimore: No. 606 E Clement St.; 37 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 13 (Day), 1854 (Year)

7-AGE, 63 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Coal Trimmer

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Andrew Rubeach

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rubeach

(Address) 606 E Clement St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1915, to Dec 6 1917, that I saw h in alive on Dec 6 1917, and that death occurred, on the date stated above, at 10:50 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) Neil Cutler M. D.

12/6, 1917. (Address) 739 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross R.C. Co

DATE OF BURIAL, 12/10, 1917

20-UNDERTAKER W. G. Flynn

ADDRESS 1422 Light St.

DEC 9 - 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10712

CERTIFICATE OF DEATH.

97 D10712

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Laurens ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy E Carter

(Residence in Baltimore: No. 517 Laurens St.; 1 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	married

6-DATE OF BIRTH, Aug. 29, 1881.
(Month) (Day) (Year)

7-AGE, 36 yrs. 3 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, ~~Unknown~~ Louisa

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Millie Bowles

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Carter

(Address) 517 Laurens St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 7 1917, and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Ac Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion - Bronchi

(Duration) yrs. mos. ds.

(Signed) Edw Thorp M. D.

12/7/17, 191... (Address) 1512 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 9, 191..

20-UNDERTAKER Geo H Holland ADDRESS 631 D-Hare

DEC 8 - 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10713 D10713

CERTIFICATE OF DEATH.

REGISTERED No. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Saunders

(Residence in Baltimore: No. 514 Lanvale St St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Widow

6-DATE OF BIRTH, Oct 15, 1862 (Month) (Day) (Year)

7-AGE, 55 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Augustine

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliz. Hogan

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Mary Booth

(Address) Calvert St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 9 1917, that I saw h[illegible] alive on Dec 9 1917, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about

(Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Myocarditis Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H. Smith M. D.

Dec 9, 1917 (Address) Maryland Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State 55 yrs. 6 mos. ..... ds.

Where was disease contracted, if not at place of death? 514 Lanvale St

Former or usual residence 514 Lanvale St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 8, 1917

20-UNDERTAKER J. H. Holland ADDRESS 1631 D Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10717

CERTIFICATE OF DEATH.

120 D10717

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Webster

(Residence in Baltimore: No. 1225 McCulloh Street St.: 57 yrs., 1 mos. 24 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 14, 1860, (Month) (Day) (Year) 1

7-AGE, 57 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retail
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Business

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John T. Webster

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Eliza A. Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eliza A. Webster

(Address) 1225 McCulloh Street

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8, 1917.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 7 1917, to Dec 8 1917, that I saw him alive on Dec 8 1917, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Probably 10 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 6 mos. 6 ds.

(Signed) J. Gudat Dece M. D.

Dec. 9, 191.. (Address) 1103 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	12.10.17 191...
20-UNDERTAKER Henry W. Meade & Son	ADDRESS 605 N. Calvert St.

Spec.—8-24-14—M. & T.—2000 Blks.

D10715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 D10715

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 N. Cross. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bailey

(Residence in Baltimore: No. 1139 W. Cross St., St.; 51 yrs., 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 1, 1866 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
51 yrs. 7 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... / House Duties
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS,

10-NAME OF FATHER, John Kettche

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Christina Grudeman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry W. Bailey

(Address) 1139 W. Cross St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 7 1917, and that death occurred, on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chron.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephr.

..... (Duration) ....yrs. 6 mos. ....ds.

(Signed) John G. Schwensky M. D.

Dec 8, 1917 (Address) 1170 W Cross

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Western Cem	Dec 10, 191[illegible]
20-UNDERTAKER	**ADDRESS**
Mrs. Mrs. John M. Tengel	801 W. Fayette St.

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10716

154

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1710 Eliden St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Schmidt

(Residence in Baltimore: No. 1710 Eliden St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Wid

6-DATE OF BIRTH, May 8, 1838
(Month) (Day) (Year)

7-AGE. 79 yrs. 8 mos. 29 ds. If LESS than 1 day, ...hrs. or.....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... Lost ft '037

9-BIRTHPLACE. (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Otto Ammerman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Dieser

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Schmidt

(Address) 1710 Eliden

15- DEC 9-1917 ROBERT B. RESLER

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Nil
..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)
....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Dec 10, 1917
20-UNDERTAKER	**ADDRESS**
Robt F Turner	1421 E Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D10717. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D10717.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Scott ST. 22 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Willett

(Residence in Baltimore: No. 205 Scott St

St.: ....yrs., 7 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.)
Fem	White	Single

6-DATE OF BIRTH, April 6, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 8 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Patrick Willett

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Virginia Kellman

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick Willett

(Address) 205 Scott St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 8 1917, that I saw h— alive on Dec 8 1917, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration)....yrs. 1 mos....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration)....yrs....mos. 14 ds.

(Signed) E V Cockburn M. D.

17 Dec, 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkelly. Va

DATE OF BURIAL, Dec....., 191...

20-UNDERTAKER W B Hilleary

ADDRESS 2236 Eutaw Ave

DEC 9 - 1917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10718

CERTIFICATE OF DEATH.

152 D10718

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 202 Otterbein ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Randall 17 hrs

(Residence in Baltimore: No. 202 Otterbein St.; 0 yrs., 0 mos. 0 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, December (Month) 8 (Day), 1917 (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 17 hrs. or ... mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Randall

11-BIRTHPLACE OF FATHER (State or Country), Calvert County Md.

12-MAIDEN NAME OF MOTHER Nora Scribers

13-BIRTHPLACE OF MOTHER (State or Country), Crisfield, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Randall

(Address) 202 Otterbein

15-

DEC 10 1917

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8 1917, to Dec 9, 1917, that I saw her alive on Dec. 9, 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) L. H. Douglass M. D.

Dec. 9, 1917. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn A- | DATE OF BURIAL, Dec 10 ..., 191...

20-UNDERTAKER J. L. Brown & Son | ADDRESS 1818 W. Mt. St.

Spec.—8-14-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10719 D10719

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Peters # 2 (Wright)

(Residence in Baltimore: No. Municipal Hosp. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
White.	Black.	Married

6-DATE OF BIRTH, 10 (Month) 28 (Day) 17 (Year)

7-AGE, ... yrs. 1 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Peters

11-BIRTHPLACE OF FATHER (State or Country), Md 518 W Lorn St

12-MAIDEN NAME OF MOTHER Agnes Wellrow.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 2 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-28 1917, to 12-2 1917, that I saw h[illegible] alive on 10-28- 1917, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

.....Prematurity, Debility.....

..... (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Enterocolitis

..... (Duration)....yrs....mos....ds.

(Signed) J. W. Bingham M. D.

....., 191... (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 10 1917

Office Inspector Health.

16351

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Mh.V. 5693

D10720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10720

REGISTERED No. C

1-PLACE OF DEATH 1406 N Monroe

CITY OF BALTIMORE (No. ~~2502 Nutley~~ ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lowe

(Residence in Baltimore: No. 1406 N Monroe St.; yrs., mos. ds.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... January ....., 18.43
(Month) (Day) (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mrs. Lowe

(Address) 1406 N Monroe

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June ..... 5 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... William ..... M. D.
(Coroner)

....., 191.. (Address) ..... 1406 N Monroe

*(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10721

CERTIFICATE OF DEATH.

REGISTERED NO. C D10721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Mty Hospital St.; City WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hurley

(Residence in Baltimore: No. West End Maternity St.; 7 hrs. yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~ Married ~~WIDOWED~~ ~~OR DIVORCED~~. (*Write* the word.)

6-DATE OF BIRTH, Dec 8, 1917. (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 7 hrs. or 30 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), West End Mty Hosp. Baltimore

PARENTS.

10-NAME OF FATHER. Norris Elmer Hurley

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER Naomi Higgins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Kolb

(Address) 1203 Light St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 8 1917, that I saw her alive on Dec 8 1917, and that death occurred, on the date stated above, at 11.20 m.

The CAUSE OF DEATH* was as follows:

Premature
seven months gestation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Kolb M. D.

Dec 8, 191.. (Address) 1203 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 305 E. West St.

19-PLACE OF BURIAL OR REMOVAL, Leader Hill

DATE OF BURIAL, Dec 10, 191..

20-UNDERTAKER John J. Fields

ADDRESS 1200 W Lombard

D10722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10722

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 511 S Regester ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bozek

(Residence in Baltimore: No. 511 S Regester St

St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Dec 8, 1916
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, 6 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter Bozek

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mary Kalen

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Bozek

(Address) 511 S Regester St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry A Duncky M. D.
(Coroner.)

Dec 6, 191... (Address) 610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rozary

DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER, Wm Falkowski

ADDRESS, 1618 Eastern ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10723

CERTIFICATE OF DEATH.

7/5 D10723

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 42 Boyd Hospital St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Shodrick.

(Residence in Baltimore: No. (Colonial Beach Va) St.; yrs.,, mos. 1 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar'd

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Wm

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L Rabbitt

(Address) Same as

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Dec 9, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State .... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Colonial Beach Va.

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Dec 10th, 191..

20-UNDERTAKER George J. Rauth. — ADDRESS 735 Harford Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10721

CERTIFICATE OF DEATH.

D10721

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 N. Pearl ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosario Messina

(Residence in Baltimore: No. 409 N. Pearl St.; 76 yrs., ..mos. ..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, June 15, 1851
(Month) (Day) (Year)

7-AGE, 66 yrs. 6 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Carlo Messina

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Parente

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincenzo Ruth

(Address) 635 E. Pleasant St

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1917, to Dec 8 1917, that I saw h.. alive on Dec 8 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma Dyspnea

(Duration) ..yrs. ..mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ..yrs. ..mos. ..ds.

(Signed) L. J. Hamburger M. D.

Dec 9, 1917 (Address) 16 E. Monty

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincent Cemetery	Dec 10th 1917
20-UNDERTAKER George J. Ruth	ADDRESS 735 Harford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PARENT, WITH CHILDREN UNDER 16 YEARS OF AGE—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10725

CERTIFICATE OF DEATH.

50 D10725

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Castle ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Smith

(Residence in Baltimore: No. 520 N. Castle St.; 58 yrs., 8 mos. 12 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March 24, 1859 (Month) (Day) (Year)

7-AGE, 58 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Street Commr

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo. F Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha A

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret E Smith

(Address) 520 N. Castle

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 6, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Dec 6 1917, that I saw h[illegible] alive on Dec 6 1917, and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carbuncle

(Duration) ... yrs. 21 mos. ... ds.

(Signed) Edward [illegible] M. D.

1717, 191.7. (Address) 1412 N Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Dec 10 191 7

20-UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

D10726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10726

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N. Caroline ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beulah Walz

(Residence in Baltimore: No. 313 N. Caroline St.; 5 yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Sept 9th, 1912 (Month) (Day) (Year)

7-AGE, 5 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John Walz

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie C. Hugel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Walz

(Address) 313 N. Caroline

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 9- 1917, to Dec 9 1917, that I saw h[illegible] alive on Dec 9- 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 1 yrs. 3 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia from birth

(Duration) yrs. mos. ds.

(Signed) Benj. F. Hayden M. D.

Dec 10, 1917, (Address) 1216 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore | DATE OF BURIAL, Dec 11 191..

20-UNDERTAKER Philip Herzog | ADDRESS 2016 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10727.

CERTIFICATE OF DEATH.

64 D10727.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 W Fayette ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Hadaway

(Residence in Baltimore: No. 1522 W Fayette St.; 79 yrs., 4 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Wht	Married

6-DATE OF BIRTH. April 24 1838
(Month) (Day) (Year)

7-AGE. 79 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Meeks

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Louisa ?

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Hadaway

(Address) 1522 W. Fayette St

15-

DEC 10 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1917, to Dec. 7 1917, that I saw h-r alive on Dec. 6 1917, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration)..... yrs. mos. ds.

(Signed) [illegible] M. D.

12-7 1917 (Address) 1302 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Dec 10th, 1917

20-UNDERTAKER Joseph B. Cook — ADDRESS 100 S Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10728

CERTIFICATE OF DEATH.

41 ✓ D10728

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110, W. Hamburg, ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Young.

(Residence in Baltimore: No. 1110 W Hamburg St.; 53 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. August (Month) 28 (Day), 1865 (Year)

7-AGE, 77 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, Chas A Young

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christina Lemmy

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Young

(Address) 1110 W Hamburg St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 7 1917, and that death occurred, on the date stated above, at 10 58 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) J. M. Lamprecht M. D.

Dec 8, 1917. (Address) J. M. Lamprecht

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem

DATE OF BURIAL. Dec 10, 1917

20-UNDERTAKER Joseph B. Cook

ADDRESS 1003 W Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PRIVILEGE, WITH PENALTY, OF USING THIS BLANK AS A PERMANENT RECORD

D10729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10729

168

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1355 Carroll ST.: Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George Summerfield

(Residence in Baltimore: No. 1355 Carroll St.: 9/6 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. ..... (Month) ....., 1 (Day) ..... (Year)

7-AGE. ..... yrs. 2 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Maryland Balto

PARENTS.

10-NAME OF FATHER. George Summerfield

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Maud Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Summerfield

(Address) 1355 Carroll St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... Dec (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Suffocation by vomit while asleep in her arms, at night Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Kenton M. D. (Coroner)

Dec 8, 1917. (Address) 700 E. Lane St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Dec 9, 1917
20-UNDERTAKER	ADDRESS
Brown & Packard Schroder	

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10730

CERTIFICATE OF DEATH.

40 D10730

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Park ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie M. Davis

(Residence in Baltimore: No. 1606 Park ave St.; 39 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	white	single

6-DATE OF BIRTH, ... Dec 6 ....., 1864
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
53 yrs. 1 mos. 2 ds.	....hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Robert H. Davis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catharine Handy

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances A. Davis

(Address) 1606 Park ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1917, to Dec 8 1917, that I saw h[illegible] alive on Dec. 8 1917, and that death occurred, on the date stated above, at 9 25 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion from

Toxaemia

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of

Liver - Incomplete ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Dec 8, 191.. (Address) 4906 Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge	Dec. 10, 1917.
20-UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10731

CERTIFICATE OF DEATH.

53 D10731

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 515 N. Carrollton Ave; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thecla Schultz

(Residence in Baltimore: No. 515 N. Carrollton Ave St.; 72 yrs., 10 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Jan (Month) 23 (Day), 1845 (Year)

7-AGE, 72 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-work,
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. Schultz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Jacobina Petry

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Ida L. Dohme

(Address) 10 Overhill Road

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th 1917, to Dec 8th 1917, that I saw h.er alive on Dec 7th 1917, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease
(Pseudoleukaemia)
about
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw. A. Bussmann M. D.

Dec 8th, 1917 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos.....ds. In the State .....yrs. .....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Dec 10 1917
20-UNDERTAKER	ADDRESS
John Ouellette	1211 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10732 HEALTH DEPARTMENT—CITY OF BALTIMORE D10732

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 W Lafayette ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Patterson Taylor

(Residence in Baltimore: No. 721 W Lafayette St.; 85 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	single

6-DATE OF BIRTH, May 15, 1832 (Month) (Day) (Year)

7-AGE, 85 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Robert Taylor

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Isabella Train

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth M Taylor

(Address) 721 W Lafayette St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 - 1917, to Dec. 9 - 1917, that I saw her alive on Dec. 8 - 1917, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pulic Congestion Gall stones
Hepatitis & Jaundice

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Jaundice

(Duration) ....yrs. ....mos. ....ds.

(Signed) Carleton Cook M. D.

Dec. 10, 1917 (Address) 1107 W Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	Dec. 12, 1917
20-UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10733

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74 ✓ D10733

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 803 Shutter ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Green

(Residence in Baltimore: No. 803 Shutter St.; 71 yrs., ... mos. ..... ds.)

Shutter

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Widower

6-DATE OF BIRTH, ... Unknown (Month), ... 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
62 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Emma Buck

(Address)..... 803 Shutter St

15-

Filed....., 191.....

Registrar.

DEC 10 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month), 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1917, to Dec. 9, 1917, that I saw h[illegible] alive on Dec. 7, 1917, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

..... (Duration)..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Gastric Catarrh

..... (Duration)..... yrs. 4 mos. ..... ds.

(Signed) J. D. Osborn M. D.

1319 Q, 191.7 (Address) 1528 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	....., 191...
20-UNDERTAKER	ADDRESS
Jno. F. A. Williams	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS CERTIFICATE, WHEN COMPLETED, BECOMES A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10731

CERTIFICATE OF DEATH.

9 V D10737

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Dallas ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Smith

(Residence in Baltimore: No. 511 N. Dallas St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June ....., 1 ..... (Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Work

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, William Brown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizbeath Campbell

(Address) 511 N. Dallas St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7th, 191 7 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/12/191 7, to 7/12/191 7, that I saw h[illegible] alive on 7/12/191 7, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

..... (Duration) one week yrs. mos. ds.

CONTRIBUTORY (Secondary) Was found dead in bed

..... (Duration) ? yrs. mos. ds.

(Signed) [signature] M. D.

12/7/, 191 7 (Address) 525 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury cemetery DATE OF BURIAL, Dec 10, 191 7

20-UNDERTAKER P. P. Gross ADDRESS 1405 McCulloh

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS CERTIFICATE, WHEN CARELESSLY FILLED OUT, BECOMES A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10735

CERTIFICATE OF DEATH.

D10735

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. President & Aliceanna St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John See

(Residence in Baltimore.—No. 1132 Sawer St

St.; yrs., 17 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eastern Police Station

(Address) Bond & Broadway

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Fracture of Ribs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Crushed by Elevator

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Ryan Coroner (Coroner) C. D.

Dec 9, 191 7 (Address) 1610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion cemetery

DATE OF BURIAL, Dec 11....., 19 7

20-UNDERTAKER P C Gross

ADDRESS 1405 Mcelderry St

Spec.—8-24-14—M. & T.—2000 Bks.

D10736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10736

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Hakesley Place St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph V. Imhoff

(Residence in Baltimore: No. 1635 Hakesley Pl. St.; 14 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 28 (Day), 1903 (Year)

7-AGE, 14 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Charles Imhoff

11-BIRTHPLACE OF FATHER (State or Country), Prince George Co. Md.

12-MAIDEN NAME OF MOTHER Annie Elsa

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul H. Imhoff

(Address) 1635 Hakesley Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11. 1917, to Dec. 7 1917, that I saw him alive on Dec. 7 1917, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. 3 mos. ds.

(Signed) W. C. Sandbeck M. D.

Dec. 8, 1917. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec. 11, 1917

20-UNDERTAKER Frank A. Kirk — ADDRESS 715 N. Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10737. D10737.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 E. Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie P. Wright

(Residence in Baltimore: No. 2508 E. Biddle St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 5, (Day) 1874 (Year)

7-AGE, 43 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. E. Fosler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Annie E. Courtney

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence H. Wright

(Address) 2508 E. Biddle

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 191, to Dec 7 1917, that I saw h a alive on Dec 6 191, and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 1 mos. ds.

(Signed) Walter A. White M. D.

Dec 7, 1917 (Address) 1 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER Zurhorst & Kirkley — ADDRESS 1734 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 10 1917

D10738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10738

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2265 Madison Ave (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Rustaum

(Residence in Baltimore: No. 2265 Madison Ave. St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) Married

6-DATE OF BIRTH May 11th, 1858.
(Month) (Day) (Year)

7-AGE, 59 yrs. 6 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Notion Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Rustaum

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ella Bachman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rustaum

(Address) 2265 Madison Ave

15-

Filed....., 191.....
Registrar.

DEC 10 1917 ROBERT B. TRAUTER REGISTRAR OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by said Inquest, autopsy or inquiry found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 8, 191... (Address) 662 Rutland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 12/10, 1917

20-UNDERTAKER J. Ahrens Co — ADDRESS [illegible]

D10739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

MAY 29 D10739

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1230 Orleans ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hanie Wadia

(Residence in Baltimore: No. 1230 Orleans St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jack Levin

(Address) 1411 E Baltimore

15-

Filed ....., 191.....

Registrar.

DEC 10 1917 ROBERT R. KRAMER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May, 29, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Henry Friedenwald Cem. DATE OF BURIAL, 1/10, 19...

20-UNDERTAKER Jack Levin ADDRESS 1411 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10740

CERTIFICATE OF DEATH.

61 D10740

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2634 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olga Ivancow

(Residence in Baltimore: No. 2634 Hudson St. St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November 24, 1912
(Month) (Day) (Year)

7-AGE, 5 yrs. — mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Peter

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Anastasia Donek

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Ivancow

(Address) 2634 Hudson St.

15-

Filed....., 191.....

Registrar.

DEC 10 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I saw h.... alive on ....191....,
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

.....
..... Meningitis
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.
Dec. 10 191.7. (Address) Health Dept.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus-Cem. DATE OF BURIAL, Dec. 10, 1917

20-UNDERTAKER Stephen J. Kraikowski ADDRESS 1019 Gunther

Spec.—5-19-13—M. & T.—500 Bks.

D10741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10741

CERTIFICATE OF DEATH.

152

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E Clement ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Marjorie Stickles

(Residence in Baltimore: No. 505 E Clement St.: — yrs., — mos. 13 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, 11 (Month) 25 (Day), 1917 (Year)

7-AGE, ...yrs. ....mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Rich A. Stickles

11-BIRTHPLACE OF FATHER (State or Country). White Post Va.

12-MAIDEN NAME OF MOTHER Ollie May Nossett

13-BIRTHPLACE OF MOTHER (State or Country). Winchester Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rich A. Stickles

(Address) 505 E Clement

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11. 25 1917, to 12. 8 1917, that I saw h[illegible] alive on 12. 8 1917, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Hemorrhage.
(Melena)

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) L. J. Burlington M. D.

12/8, 1917 (Address) 1026 Fortan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Winchester Va.

DATE OF BURIAL. 12/11, 1917

20-UNDERTAKER L. Fen McCully

ADDRESS 130 E. Fortan

DEC 10 1917 Forest [illegible] Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10742

D10742

CERTIFICATE OF DEATH.

REGISTERED NO. C 118

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Banks

(Residence in Baltimore: No. 1017 Bruce St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS STATEMENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown ....., 1891
(Month) (Day) (Year)

7-AGE 26 yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Banks

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Banks.

(Address) 1017 N Bruce st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1917, to Dec 5 1917, that I saw him alive on Dec 5 1917, and that death occurred, on the date stated above, at 8 10 p.m.

The CAUSE OF DEATH* was as follows:

General peritonitis due to ruptured ant-phlegmonous abscess

(Duration) ..... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J A Dandridge M. D.

Dec 8, 1917 (Address) Md Gen Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 7 ds. In the State 26 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1017 Bruce St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Pennsylvania Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

*1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Baker

(Residence in Baltimore: No. 1017 Bruce St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., (Month) ..... (Day) 1 (Year)

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dyetaster
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 5, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1917, to Dec 5 1917, that I saw h.. alive on Dec 5 1917 and that death occurred, on the date stated above, at 8:45 p. m.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis.

..... General paralysis

..... (Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Contributory failure

..... (Duration) yrs. mos. ds.

(Signed) J. A. Darden M. D.

12/5, 191.7 (Address) 100 Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 5 ds. In the State 26 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1017 Bruce St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL. ....., 191...
20-UNDERTAKER	ADDRESS

Spec.—8-24-14—M&S T.—2000 Blks.

D10743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 Wilmer Ave; St. 17 WARD)

REGISTERED No. C 1720 D10743

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H Samuel

(Residence in Baltimore: No. 745 Wilmer Av St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) August (Day) ..... 18 13 (Year)

7-AGE, 74 yrs. 3 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sample carrier
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), State of Virginia County

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Lettie Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Williams

(Address) 629 George St

15-

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 7 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 191 7, to Dec 7 191 7, that I saw h alive on Dec 7 191 7, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(Duration) 0 yrs. 10 mos. 0 ds.

CONTRIBUTORY (Secondary) None

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) R B Kenyon M. D.

Dec 7, 191... (Address) 432 N Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [redacted] Cemetery

DATE OF BURIAL, Dec 10, 1917

20-UNDERTAKER Chas G Bailey

ADDRESS 1 Jefferson St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—7000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10747

CERTIFICATE OF DEATH.

19 D10747

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Park Ave. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Hamilton

(Residence in Baltimore: No. 1312 Park Avenue St.; 7 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widowed

6-DATE OF BIRTH, April (Month) 6th (Day), 1838 (Year)

7-AGE, 79 yrs. 8 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), New York City

PARENTS.

10-NAME OF FATHER, Reginald Pond

11-BIRTHPLACE OF FATHER (State or Country), Vermont

12-MAIDEN NAME OF MOTHER Harriet S Taylor

13-BIRTHPLACE OF MOTHER (State or Country), New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Hamilton

(Address) 1312 Park Ave Baltimore

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 24 1917, to Dec 10th 1917, that I saw her alive on Dec. 9th 1917, and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvula Heart Lesion
With Disturbed Compensation

(Duration) several years yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchus Pneumonia

(Duration) 2 wks. yrs. mos. ds.

(Signed) J Wray Thurman M. D.

Dec 10, 1917. (Address) The Leamedan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Saybrooke Conn — DATE OF BURIAL, Dec 11, 1917

20-UNDERTAKER Jas B Spence — ADDRESS 1535 N Caroline

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 10 1917 ROBERT E. FRAZIER

Spec.—8-24-14—M. & T.—2000 Bks.

D10745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 9 WARD)

REGISTERED NO. C 1276

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Black Sr.

(Residence in Baltimore: No. 2229 Homewood Ave St.; 60 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, July (Month) 7 (Day) 1830 (Year)

7-AGE, 87 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad H. Black

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Frederica Heise

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. E. Black Jr.

(Address) 500 E. 20th St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1917 (Year)

17-D I HEREBY CERTIFY, That I attended deceased from Sept. 15 1916, to Dec 7 1917, that I saw him alive on Dec 9 1917, and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

I. (a) Pneumonia, Lobar
(b) Edema, Pulmonary, Acute
(c) Myocarditis
(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis, Cerebral Hemorrhage, Hypostatic Congestion
(Duration) 8 yrs. mos. ds.

(Signed) Chas. E. Black M. D.

Dec 9, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 2 mos. 24 ds. In the State 60 yrs. mos. ds.

Where was disease contracted, if not at place of death? 2229 Homewood Ave

Former or usual residence 2229 Homewood Ave

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, 12-12, 1917.

20-UNDERTAKER John B. Spence ADDRESS 1325 N Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D10746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10746

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Brunt ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME George V Knight

(Residence in Baltimore: No. 1834 Brunt St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	white	single

6-DATE OF BIRTH, March 16, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Knight

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Norton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Knight

(Address) 1834 Brunt St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 191 7, to Dec 9 191 7, that I saw h[illegible] alive on Dec 9 191 7, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. 1 mos. 1 ds.

(Signed) J C Hazel M. D.

Dec 9/19 191... (Address) 1734 Mortim

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Dec 11, 1917.

20-UNDERTAKER, Martin Fahey Jr Sons — ADDRESS, 606 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10747.

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH St Vincent Inf Asylum

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marguritte Fiene,

(Residence in Baltimore: No. 1401 Division St.; ....yrs., 7 mos. 5 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	Col'd.	Single

6-DATE OF BIRTH, ...Jan (Month) 17 (Day), 1917. (Year)

7-AGE, ...yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Martin Fiene

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lillie Wittle

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Russum

(Address) 1401 Division St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec Ember 8, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1917, to Dec 8th, 1917, that I saw her alive on Dec 7th, 1917, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) Lenard M C Tucker M. D.

....., 191... (Address) 625 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 7 mos. 5 ds. In the State ....yrs. 10 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 816 S. Curley St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Dec 10, 1917.

20-UNDERTAKER M Fahey & Sons ADDRESS 626 Lafayette Av

Spec.—8-24-14—M. & T.—2000 Bks.

D10748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10748

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Curtis

(Residence in Baltimore: No. 3220 Barclay St. Balt Md St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF ~~BIRTH~~, Nov. 25 (Month) (Day), 1917 (Year)

7-AGE, ...yrs. 2 mos. ...da. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Lucy Curtis

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ...

(Address) Johns Hopkins Hospital

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9 (Month) (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1917, to Dec 9 1917, that I saw her alive on Dec 9 1917, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

...spasmodic intestinal indigestion acute

...

...

... (Duration) ...yrs. ...mos. 30 ds.

CONTRIBUTORY (Secondary) ...marasmus...

... (Duration) ...yrs. ...mos. 10 ds.

(Signed) ... M. D.

Dec 10, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 16 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence 3220 Barclay Street

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, ..., 191...

20-UNDERTAKER Mrs Robert Elliott ADDRESS 506 Lafayette Ave

D10749 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D10749

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2028 W. Lanvale ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles V. McCall

(Residence in Baltimore: No. 2528 Emerson St. St. 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word): married

6 DATE OF BIRTH: Oct (Month) 26 (Day), 1892 (Year)

7 AGE: 25 yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): in shirt factory

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: James McCall

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Baker

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ferdinand C. Wardell

(Address) 2025 W. Lanvale St.

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 9 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th, 1917, to Dec 8 1917, that I saw him alive on Dec 8, 1917, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) C. Emil Cookus M. D.

Dec 9, 1917 (Address) 252 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oak Lawn Cem't

DATE OF BURIAL: Dec 4, 1917

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nath

Spec.—8-24-14—M. & T.—2000 Bks.

D10750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10750

CERTIFICATE OF DEATH.

81

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 S. Lakewood ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Winks

(Residence in Baltimore: No. 714 S Lakewood St.; Yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dont Know (Month) 1 (Day) (Year)

7-AGE, About 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) on Water

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Winks

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Winks

(Address) 714 S. Lakewood

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1917, to Dec 8th 1917, that I saw him alive on Dec 7th 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Aneurysm Aorta

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. A. Ahern M. D.

Dec 10th, 191.. (Address) 1003 Pollen St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oaklawn County DATE OF BURIAL, 12/11, 191.7

20-UNDERTAKER William Cook ADDRESS 502 E. North Ave

DEC 10 1917

Registrar's Office

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10751 D10751

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. ..... ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Mielland

(Residence in Baltimore: No. Little Sisters of the Poor St.: ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid.

6-DATE OF BIRTH, ... (Month) ..... (Day) 18.40 (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas Mc Guniss

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Doude

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

Registrar.

DEC 10 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 28 1917, to ..... 191..., that I saw her alive on Dec 9 1917, and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Warner M. D.

Dec 10, 1917 (Address) 1127 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death / yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, Dec. 12, 1917

20-UNDERTAKER H. C. Woodfield ADDRESS 914 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10752

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH Little Sisters of the Poor 79

CITY OF BALTIMORE: (No. ..... ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Logue

(Residence in Baltimore: No. Little Sisters of the Poor St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1837 (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Michael Logue

11-BIRTHPLACE OF FATHER (State or Country), Cuba

12-MAIDEN NAME OF MOTHER Alice Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Cuba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedicta

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 ,
that I saw h alive on Dec 7 191 7,
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage
..... Arteriosclerosis
..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
Dec 9, 1917 (Address) 1328 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 70 yrs. mos. ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, St Vincents Cem. DATE OF BURIAL, Dec 11, 1917

20-UNDERTAKER H. C. Nudorfer ADDRESS 94 Grand Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10753 HEALTH DEPARTMENT—CITY OF BALTIMORE D10753

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Washington ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Weniger.

(Residence in Baltimore: No. [redacted] S. Washington St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Aug 22nd (Month) (Day), 1863. (Year)

7-AGE. 19 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Joseph Weniger.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Barbara Hacke.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Weniger

(Address) 114 S. Washington St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 7th (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1916, to Dec. 7 1917, that I saw him alive on " " 1917, and that death occurred, on the date stated above, at 5½ p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) H. Hollenberg M. D.

Dec. 9, 1917. (Address) 1810 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State Sabillasville yrs. 17 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Dec. 11th, 1917.

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E. Mills

(Residence in Baltimore: No. 125 E. St. N.W. Washington D.C St.; yrs., mos. 1½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Insurance
(b) General nature of industry, business, or establishment in which employed (or employer)..... Agent

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph M. Mills

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Adams

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph M. Mills

(Address) Washington D.C

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Cerebral Hemorrhage (apoplexy)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Driscoll M. D.
(Coroner.)

Dec 10, 1917. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wash D.C.	12/11, 1917
20-UNDERTAKER Henry W. Mumford	ADDRESS 105 N. Gay St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 10 1917 BUREAU OF VITAL STATISTICS Burial Permit

630 86

To Adams Express

Spec.—8-24-14—M. & T.—2000 Blks.

D10755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10755

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 West North Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa V. Keehan

(Residence in Baltimore: No. 729 West North Ave.

St.; 54 yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. October 14, 1863, 1
(Month) (Day) (Year)

7-AGE. 54 yrs. 1 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): No

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Patrick Keehan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Mooney

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Keehan

(Address) 729 West North Ave.

15-

Filed ....., 191....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24th 1917, to Dec 5th 1917, that I saw her alive on December 6th 1917, and that death occurred, on the date stated above, at about 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Lingual Cancer

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. F. Lochmann M. D.

Dec 10, 1917. (Address) 5 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	12/11/17

20-UNDERTAKER Henry W. Maas & Son

ADDRESS 808 N. Gilmor St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10756 HEALTH DEPARTMENT—CITY OF BALTIMORE V D10756

CERTIFICATE OF DEATH.

REGISTERED NO. C 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera apts ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia S. Kerrigood

(Residence in Baltimore: No. Rivera apts St.: 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Sept 23, 1849 (Month) (Day) (Year)

7-AGE, 73 yrs. 2 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) 4

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Sol Knobaum

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorkeen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. S. Kerrigood

(Address) Riviera apts

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28 191 7, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Influenza, Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. 1 ds.

(Signed) C. Ther[illegible] M.D.

Dec 16 191 7 (Address) 2 E. 31 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ket Sholom Cem. DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER J. Rieman & Co ADDRESS 1510 Mass

CAUSE OF DEATH in plain terms, so that it may be properly classified. Must be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10757.

CERTIFICATE OF DEATH.

28 ✓ D10757.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Durham ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Davis

(Residence in Baltimore: No. 233 N. Durham St.; 10 yrs.. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Black; a. G.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 16, (Month) (Day) 1879 (Year)

7-AGE, 38 yrs. 8 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wesley Davis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Davis

(Address) 233 Durham St

15-

Filed....., 191.....

Registrar.

DEC 11 1917 ROBERT R. CRADDOCK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9, (Month) (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1917, to Dec. 9, 1917, that I saw him alive on Dec. 8, 1917, and that death occurred, on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12/10/17, 191.. (Address) 520 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arbury Cem

DATE OF BURIAL, Dec. 11, 1917.

20-UNDERTAKER Harry A. Vodery

ADDRESS 1325 Orleans St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10753

CERTIFICATE OF DEATH.

40 ✓ D10758

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Rosedale ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Inale

(Residence in Baltimore: No. 1907 Rosedale St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH ..... Sept. (Month) 24 (Day), 1865 (Year)

7-AGE, 52 yrs. 2 mos. 15 ds. — If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Coffee 066
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Salesman

9-BIRTHPLACE. (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, Joseph P. Inale

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Eliza Torey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Inale

(Address) 1907 Rosedale St.

15-

DEC 11 1917

Filed ....., 191.....

ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29" 1917, to Dec 9" 1917, that I saw h*im* alive on Dec 9" 1917, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(Duration) 1 yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Herbert A. Bekeh M. D.

Dec 9", 1917. (Address) 3050 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	Dec. 12, 1917
20-UNDERTAKER	ADDRESS
Josiah Leffler	1600 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10759

CERTIFICATE OF DEATH.

+92 D10759

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry B. Christhilf

(Residence in Baltimore: No. Mercy Hospital St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, May 21, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wholesale Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): " " 634

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry B. Christilf

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dora Eckaffer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp.

15-

DEC 11 1917 CORTEZ R. KRAUTER (Clerk)

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16 1917, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis + acute Cardiac Dilatation

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Edward H. Smith M. D.

Dec. 10, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 75 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Cedar Croft Md.

Former or usual residence Cedar Croft Md.

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, 12-12, 1917.

20-UNDERTAKER Henry W. Jenkins Son & ADDRESS Orchard & McCulloh St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10760

CERTIFICATE OF DEATH.

64 D10760

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Mosling Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Ellis

(Residence in Baltimore: No. 1308 Mosling Ave. St.; 14 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Feb 5, 1860 (Month) (Day) (Year)

7-AGE, 57 yrs. 10 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) (at Home)

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, William H Davis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Sarah Davis

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Ellis

(Address) 1308 Mosling Ave.

15-

Filed ....., 191.....

Registrar.

DEC 11 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29th 1917, to Dec 8th 1917, that I saw her alive on 191, and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Tate M. D.

Dec 11, 1917. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Marys Cemetery	Dec 12, 191...
20-UNDERTAKER Townsend & Son	ADDRESS 20 Mulberry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10761

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10761

1 PLACE OF DEATH

REGISTERED NO. C 154

CITY OF BALTIMORE (No. 1509 W 36th St. ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Anna Stall

(Residence in Baltimore: No. 1509 W 36th St St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Divorced

6 DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7 AGE: 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Meat Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Cafe

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Henry Stall

11 BIRTHPLACE OF FATHER (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Mary A Stall

13 BIRTHPLACE OF MOTHER (State or country): Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Stickley

(Address) 1509 W. 36 St

15

Filed , 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 10th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1917, to, Dec 8 1917, that I saw h~~er~~ alive on Dec 8 1917, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile debility.

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Dr. Saundersburn M. D.

Dec 8, 191 7 (Address) 846 W 36th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olive Cem Plant Co. DATE OF BURIAL: Dec 12, 191 7

20 UNDERTAKER: Ellsworth & Son ADDRESS: 36 Johnston Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10762 D10762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1606 N Bethel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian E. McGee

(Residence in Baltimore: No. 1606 N. Bethel St.; yrs., mos. 18 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. November 22nd, 1917 (Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. James P McGee

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Katharine J. Lafferty

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. James P. McGee

(Address) 1606 N. Bethel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1917, to Dec 10 1917, that I saw her alive on Dec 10 1917, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Convulsions + Cardiac Insufficiency

(Duration) Convulsions 4 yrs. mos. ds. Cardiac Failure 10 7 months

CONTRIBUTORY (Secondary) Pneumonia Bilat.

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. C. Carman M. D.

Dec 10, 1917. (Address) 127 N Carlton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL, Dec 12, 1917.

20-UNDERTAKER. Henry Storck & Son

ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D10763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10763

CERTIFICATE OF DEATH.

29

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Stirling ST.; 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Burrier

(Residence in Baltimore: No. 934 Stirling St.; 2 yrs., 7 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, April 27, 1915 (Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, John M. Burrier

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mamie C. Dietz

13-BIRTHPLACE OF MOTHER (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mamie C. Burrier

(Address) 934 Stirling St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10th, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1917, to Dec 10th, 1917, that I saw h alive on Dec 10th, 1917, and that death occurred, on the date stated above, at 10:19 m.

The CAUSE OF DEATH* was as follows:

a Pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) H. B. Fuller M. D.

Dec 11th, 1917. (Address) 1504 E Oriole

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Dec. 12, 1917

20-UNDERTAKER Henry Hoeck & Son

ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10761

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Rutland ave ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred R. Boettger

(Residence in Baltimore: No. 1032 Rutland Ave St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 14 (Day) 1868 (Year)

7-AGE, 49 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Transfer $12 86
(b) General nature of industry, business, or establishment in which employed (or employer): Business

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Otto Boettger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bertha Baier

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Boettger

(Address) 1032 Rutland

15-

Filed....., 191.....

Registrar.

DEC 11 1917 ROBERT R. KRAUTER REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1916, to Dec 8 1917, that I saw h[im] alive on Dec 8 1917, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Contributory)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter W. White M. D.

....., 191... (Address) 101 E. Read Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore County.	Dec. 11, 1917.
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10765 HEALTH DEPARTMENT—CITY OF BALTIMORE D10765

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genl Hosp St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Stevens

(Residence in Baltimore: No. 1028 N. Stockton St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown ....., 1881
(Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Addie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bowser

(Address) 1203 Druid St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Dec 10 1917, that I saw h. alive on Dec 10 1917, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

(a) General Miliary tuberculosis

.....

..... (Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Cause Undetermined

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. H. Saunders M. D.

12/10, 1917 (Address) Md Gen Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 21 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1028 Stockton St.

19-PLACE OF BURIAL OR REMOVAL, Dead Man — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Barnes & Orr — ADDRESS 1136 Mary

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10766

CERTIFICATE OF DEATH.

64 D10766

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1227 E Madison St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel E Craft

(Residence in Baltimore: No. 1227 E Madison St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March. 17., 1873
(Month) (Day) (Year)

7-AGE, 44 yrs. 8 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brass Polisher
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles E Craft

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Annie E Craft

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver T. Craft

(Address) 1227 E. Madison

15-

Filed....., 191.....
Registrar.

DEC 11 1917 ROBERT E. PATTEN BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1916, to Dec 10 1917, that I saw h.. alive on Dec 10 1917, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. 1 ds.

(Signed) J. E. Bamboek M. D.

Dec 11, 1917. (Address) 1322 Mott

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Dec. 13, 191.7

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. Nord Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10767

CERTIFICATE OF DEATH.

40 D10767

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. S.E. corner 33rd & Greenmount ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Bauer

(Residence in Baltimore: No. 33rd & Greenmount St. 33 ? yrs. ? mos. ? ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. ? ?, 1884
(Month) (Day) (Year)

7-AGE. 33 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Gover

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John N Bauer
(Address) Edwood

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 10 1917, that I saw her alive on Dec 10 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter D Bacon M. D.

Dec 10, 191.. (Address) 100 E 20th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart	Dec 13, 191..
20-UNDERTAKER Williams Coo & Co	ADDRESS 502 E. North Ave

Dr Bacon 100 - E - 20th Street

Spec.—5-19-13—M. & T.—500 Bks.

D10768

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D10768

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 So Charles ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Dean

(Residence in Baltimore: No. 1440 So Charles St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 24, 1845 (Month) (Day) (Year)

7-AGE, 71 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Motorman Retired
(b) General nature of industry, business, or establishment in which employed (or employer): P R

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dean

(Address) 1440 S. Charles St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5, 1917, to Dec 9 1917, that I saw h[illegible] alive on Dec 8 1917, and that death occurred, on the date stated above, at 7.40 m., The CAUSE OF DEATH* was as follows:

Labor pulmonary

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ...yrs. 6 mos. ...ds.

(Signed) [illegible] M. D.

Dec 10 1917. (Address) 1[illegible] St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, MD Oliver Co

DATE OF BURIAL, Dec 11, 1917

20-UNDERTAKER Prof. E. E. Evans & Son

ADDRESS 1428 S. Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 11 1917 ROBERT E. McAULEY

D10769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10769

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 623 E Fleet St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Hirt

(Residence in Baltimore: No. 623 E. Fleet St.; yrs., mos. ds.)

N. B.—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, March (Month) 11 (Day), 1 (Year)

7-AGE, 37 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk Office

9-BIRTHPLACE. (State or Country), Newark N. J.

PARENTS.

10-NAME OF FATHER, James H. Hirt

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER, Anna Kreutler

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred W. Hirt

(Address) 72 W. Madison ave. Balto.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6, (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Cerebral Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Dec 10, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	Dec 11, 1917

20-UNDERTAKER	ADDRESS
C. V. Nanney 1935	Lafayette, av

D10770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10770

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1107 Briscoe St. St.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Jackson.(C)

(Residence in Baltimore: No. 1107 Briscoe St. St.; 1 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, Do not know., 1 (Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in glass factory.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Jackson.(C) husband.
(Address) 1107 Brisoe St.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Dec. 10th. 191 7. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn ✕	Dec 11 1917
20-UNDERTAKER	ADDRESS
A. L. Brown & Son	1017 W. Monty

D10771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10771

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 805 Peach Alley. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Richardson.(C)

(Residence in Baltimore: No. 805 Peach Alley. St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, January 12th. 1880., / (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
37 yrs. 10 mos. 28 ds.	....hrs. or....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): Hsw

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country) Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country) Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Richardson.(son)

(Address) 805 Peach Alley.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease at the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Ste. M. Reinhardt M. D. (Coroner)

Dec. 11th. 1917. (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec....., 19.7.
20-UNDERTAKER	ADDRESS
S. Lee Brown & Son	1018 W. Saratoga

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10772 D10772

CERTIFICATE OF DEATH.

28

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 S. Patterson Park ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Stent W. Hasson

(Residence in Baltimore: No. 402 S. Patterson Park ave St.; 28 yrs., 7 mos. 24 ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Single

6-DATE OF BIRTH, Apr. (Month) 15 (Day), 1889 (Year)

7-AGE, 28 yrs., 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fr. Engineer 30
(b) General nature of industry, business, or establishment in which employed (or employer). Paving Contr.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Dennis Hasson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Barbara Dunkle

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant Mrs. Mary Hastings sister)

(Address) 1238 N. Gay St.

15-

Filed....., 191.....

Registrar.

DEC 11 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 7 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 6 1917, to Dec. 7— 1917, that I saw him alive on Dec. 8 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intramitis

(Duration) 4h yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) Bond Dittmar M. D.

Dec. 11, 1917 (Address) 1216 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER John A. Horan & Co. — ADDRESS Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10773

CERTIFICATE OF DEATH.

64 D10773

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 S Paca ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Krause

(Residence in Baltimore: No. 914 S Paca St.; ..... yrs., ... mos. ..... ds.)

Gfr

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, January 24 (Month) (Day), 1843 (Year)

7-AGE 74 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Leonard Krause

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred L Krause

(Address) 719 Columbia ave

15-

Filed ....., 191.....

Registrar.

DEC 11 1917 GEORGE B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 9 1917, that I saw him alive on Dec 9 1917, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm Hoag M. D.

Dec 9, 191 7 (Address) 714 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL. Dec 11 191 7

20-UNDERTAKER W J Tuckett & Son

ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

D10771 HEALTH DEPARTMENT—CITY OF BALTIMORE

103 D10771

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 744 St Peter ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E Cain

(Residence in Baltimore: No. 744 St Peter St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Aug (Month) 22 (Day), 1843 (Year)

7-AGE, 74 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm Glass

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Laura Stuart

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E Cain

(Address) 744 St Peter St

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Dec 8 1917, that I saw h alive on Dec 8 1917, and that death occurred, on the date stated above, at 9-30 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) J M Lamprecht M. D.

Dec 10, 191 7 (Address) 826 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 11, 1917

20-UNDERTAKER H J Richardson

ADDRESS Pimlico

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH CARBON INK. THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10775

CERTIFICATE OF DEATH.

+167 D10775

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catharine Moore

(Residence in Baltimore: No. 113 Birchwood Ave. St.; yrs. 29 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Nov. (Month) 1 (Day) ..... (Year)

7-AGE, ... yrs. 29 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John T. Rollins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catharine Krebs

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. Moore

(Address) 113 Birchwood Ave.

15-

Filed ....., 191.....

Registrar.

ROBERT R. KRAUTER
DEC 11 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 8, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, accidental, while dying hair (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec. 8, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oakdawn

DATE OF BURIAL, Dec. 11, 1917

20-UNDERTAKER Jno. Crockson

ADDRESS 1906 Eastland Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1180

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10776

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

41 D10776

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 720 School St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Clarke Darnell.

(Residence in Baltimore: No. 720 School St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 1 (Month) 8 (Day) , 1848 (Year)

7 AGE: 69 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Irvington Va

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (State or country): Va.

12 MAIDEN NAME OF MOTHER: Georgia Williams

13 BIRTHPLACE OF MOTHER (State or country): Irvington Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Darnell

(Address) 720 School St

15.

Filed , 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 8 (Day) , 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1917, to Dec 7th 1917.

that I saw h[illegible] alive on Dec 7th, 1917.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY) Malarial Fever

(Duration) yrs. mos. 7 ds.

(Signed) C D Burton M. D.

Dec 8th, 1917. (Address) 402 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn | DATE OF BURIAL: Dec 12, 1917

20 UNDERTAKER: Edward Dungy & Co | ADDRESS: 1163 N Carey

Spec.—8-24-14—M. & T.—2000 Bks.

D10777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10777

150

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Collins

(Residence in Baltimore: No. 769 Columbia Ave. St.: ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Child

6-DATE OF BIRTH, Oct 22, 1911.
(Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. 18 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of Industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Collins

11-BIRTHPLACE OF FATHER (State or Country), Texas

12-MAIDEN NAME OF MOTHER Lula Wright

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Kirby

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 5 1917, to Dec. 10 1917, that I saw him alive on Dec 10 1917, and that death occurred, on the date stated above, at 5 00 ~~A~~ P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Patent Ductus Botalli (Congenital Malformation of Heart)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. M. Rivers M. D.

Dec. 10, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 769 Columbia Ave.

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec. 11, 1917.

20-UNDERTAKER, James Dignan & Son

ADDRESS 1000 S. Paca St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10778

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Etting ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mumia Brooks -

(Residence in Baltimore: No. 2212 Etting St.; 20 yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	Colored	Married

6-DATE OF BIRTH, Unknown (Month), (Day), 1877 (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Cook (b) General nature of industry, business, or establishment in which employed (or employer): Pvt Occupation

8 26

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, not known.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER not known -

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Brooks -

(Address) 2212 Etting st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5th 1917, to Dec 9th 1917, that I saw h[illegible] alive on Dec 9th 1917, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(Duration) XX yrs. 5 mos. X X ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry T. Brown M. D.

Dec 10, 191.7 (Address) 1531 Presstman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Port Auburn	Dec 12 191[illegible]
20-UNDERTAKER James H. Dennis	ADDRESS 1303 Prestman

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10779

CERTIFICATE OF DEATH.

7 D10779

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Orchard ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Wormley

(Residence in Baltimore: No. 436 Orchard St St.; 22 yrs., 1 mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Blk	Single

6-DATE OF BIRTH, November (Month) 8th (Day) 1895 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. 1 mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Op

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Virginia Fortune

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Wormley

(Address) 436 Orchard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 10th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10th 1917, to Dec 10th 1917, that I saw h-r alive on Dec 9th 1917, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1a mos. ds.

(Signed) A. T. Bledsoe M. D.

Dec 10th, 191.7 (Address) 1511 Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn Cem	Dec 12, 191.7

20-UNDERTAKER Geo K Holland | ADDRESS 131 E Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

D10780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10780

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N Central Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Green

(Residence in Baltimore: No. 425 N Central Ave St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June ..., 1 ... (Month) (Day) (Year)

7-AGE, 49 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer General
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country). Saint Marys Co Md

PARENTS.

10-NAME OF FATHER. William Green

11-BIRTHPLACE OF FATHER (State or Country). Saint-Marys Co Md

12-MAIDEN NAME OF MOTHER Mollie Price

13-BIRTHPLACE OF MOTHER (State or Country). Saint-Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) His Wife Susan Green

(Address) 425-N Central Ave

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 191 7, to Dec 9th 191 7, that I saw h[illegible] alive on Dec 9th 191 7, and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 7 yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

Dec 12, 1917 (Address) 220 N Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Saint-Peters Cem

DATE OF BURIAL, Dec 13..., 1917

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10781

D10781

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 S. Carrollton Av. ST.; 18 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William I. Hammett

(Residence in Baltimore: No. 8 S. Carrollton Av. St.; 44 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March (Month) 31 (Day), 1856 (Year)

7-AGE. 61 yrs. 8 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Harnessmaker
(b) General nature of industry, business, or establishment in which employed (or employer): for himself

9-BIRTHPLACE, (State or Country), Thurmont, Md.

PARENTS.

10-NAME OF FATHER, David Hammett

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah A. Eigenbrodt

13-BIRTHPLACE OF MOTHER (State or Country), Thurmont, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret M. Hammett

(Address) 8 S. Carrollton Av.

15-

Filed ....., 191.....

Registrar.

DEC 11 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9th (Month) Dec 9th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about Oct 1917, to Dec 9th 1917, that I saw him alive on Dec 9th 1917, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

Primary Aortic Stenosis
followed by Hypertrophy
(Duration) Supposed yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of
Heart (Duration) Supposed yrs. mos. ds.

(Signed) W. H. Hill M. D.

Dec 10th 1917 (Address) 400 S. Carr

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Dec 11th, 1917

20-UNDERTAKER Joseph D. Cook ADDRESS 1031 Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D10782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10782

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3141 Dillon St ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul J. N. Hisley

(Residence in Baltimore: No. 3141 Dillon St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1915 (Year)

7-AGE, 2 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Edward Hisley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City.

12-MAIDEN NAME OF MOTHER Teresa D. Gebhardt.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Hisley

(Address) 3141 Dillon St.

15-

Filed....., 191.....

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 10 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 9 1917, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 191, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

.....

Convulsions

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. [illegible] M. D.

Dec 10, 191.7 (Address) [illegible] Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Rd Sacred Heart Cem DATE OF BURIAL. Dec 12, 191 7.

20-UNDERTAKER Lilly & Zeile ADDRESS 403 S Mary

Spec.—8-24-14—M. & T.—2000 Bks.

D10783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10783

CERTIFICATE OF DEATH.

31

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 E Clement ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Lee Scott

(Residence in Baltimore: No. 128 E Clement St. 53 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Jan 8, 1864.
(Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Motorman
(b) General nature of industry, business, or establishment in which employed (or employer): St Car Co

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Scott

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary Deans

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Scott

(Address) 128 E Clement St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1917, to Dec 8 1917, that I saw him alive on Dec 8 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous enteritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Neale Stuart M. D.

12/9, 1917. (Address) 1049 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, CEDAR HILL

DATE OF BURIAL, DEC 12 1917

20-UNDERTAKER ARMSTRONG-DENNY CO.

ADDRESS 715 Light St

DEC 11 1917 ROBERT R. REMSEN BURIAL PERMIT CLERK

13

Spec.—8-24-14—M. & T.—2000 Blks.

D10781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10781

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 180 S Maryland St. ; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abner Smith

(Residence in Baltimore: No. 167 Dolphin St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male.

4-COLOR OR RACE, black.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, (Month) Dec. (Day) 10, (Year) 1870.

7-AGE 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Isaac Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Fannie Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Jones

(Address) 5057 Biddle St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec. (Day) 10, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from Dec 7— 1917, to Dec 7— 1917, that I saw him alive on Dec 7— 1917, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia,

(Duration) yrs. mos. 1 ds.

(Signed) Benj. M. Joyce M. D.

Dec 10, 1917. (Address) 1 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 167 Dolphin St.

19-PLACE OF BURIAL, OR REMOVAL, Mt Olivet Cem. | DATE OF BURIAL, Dec 11, 1917.

20-UNDERTAKER Samuel Hunting | ADDRESS 575 W Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10785 HEALTH DEPARTMENT—CITY OF BALTIMORE D10785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 209 Madeira ST.: 6 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Franklin

(Residence in Baltimore: No. 262 Duncan St St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: William Franklin

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Louisa Brown

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Franklin

(Address) 262 S. Duncan St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Dunst M. D.
(Coroner.)

Dec 10, 1917 (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER John C Henderson — ADDRESS 317 Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D10786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D10786

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospt. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dewey Bell.

(Residence in Baltimore: No. 586 Green Willow St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sin.

6-DATE OF BIRTH, ... (Month) ....., 1900 (Year) (Day)

7-AGE, 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. Bell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha Boyer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Bell

(Address) 586 Green Willow St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1917, to Dec 11 1917, that I saw h[im] alive on Dec 11 1917, and that death occurred, on the date stated above, at 1.25 a m.

The CAUSE OF DEATH* was as follows:

..... Abs. Diffuse Peritonitis

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. J. Baumgarten M. D.

12-11, 1917. (Address) Univ. Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 3 ds. In the State 5 yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 586 Green Willow St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 14, 1917.

20-UNDERTAKER Daniel Easton — ADDRESS 716 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10787

CERTIFICATE OF DEATH.

13 D10787

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Baker

(Residence in Baltimore: No. 1701 Ashburton St; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July 28 (Month) (Day), 1867 (Year)

7-AGE, 50 yrs. 4 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Patrick H. Connorton

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Matilda Charnock

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry V. Baker

(Address) 1812 Ashburton St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 10 1917, that I saw her alive on Dec 10 1917, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (Duration) ..... yrs. ..... mos. 2 ..... ds.

(Signed) W H Lester M. D.

Dec 10, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 23 ds. In the State 20 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Tangier Islands Va.	Dec 12, 1917.
20-UNDERTAKER	ADDRESS
Mrs Thos John H. Tenfel	831 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Lid 1741

Pin. Pratt St. B.C.a.

Spec.—8-24-14—M. & T.—2000 Bks.

D10788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10788

T53

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo Adair

(Residence in Baltimore: No. 1 mo. 3 days St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 8 (Month) (Day), 1890 (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman Pattern Makers
(b) General nature of industry, business, or establishment in which employed (or employer): Jas. Stewart & Co.

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Alonzo E Adair

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Ella L Finney

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 9 1917, to Dec 11 1917, that I saw h alive on December 11 1917, and that death occurred, on the date stated above, at 1 30 p m.

The CAUSE OF DEATH* was as follows:

Lymphatic Carcinomatosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Renal Affection

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) C P Bloom M. D.

Dec 11, 191.. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 147 Randolph Place N.W Washington D C

19-PLACE OF BURIAL OR REMOVAL, Columbus Ohio — DATE OF BURIAL, Dec 13, 191.7

20-UNDERTAKER Albert C Fuller — ADDRESS 221 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks. Her Fair

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10789

CERTIFICATE OF DEATH.

120 ✓

D10789

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2406 Montebello Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Belle Price

(Residence in Baltimore: No. 2406 Montebello Av St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept. (Month) (Day) 1877. (Year)

7-AGE, 38 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Wilmington Del.

PARENTS.

10-NAME OF FATHER, Albert H Pace

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Isabell Jaquett.

13-BIRTHPLACE OF MOTHER (State or Country), Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Pace

(Address) 2406 Montebello Av

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 10th (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1916, to Dec 10th 1917, that I saw h[illegible] alive on Dec 9th 1917, and that death occurred, on the date stated above, at [illegible] m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm A Pace M. D.

Dec 11, 1917. (Address) 12 E Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet — DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER Wm Cook — ADDRESS 502 E Lord

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D10790 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10790

CERTIFICATE OF DEATH.

REGISTERED No. C 64 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Chester ✓ Bond St. ✓ ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E Benz

(Residence in Baltimore: No. 4 11 S Regester St ✓ St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown (Month), ... 1 (Day), ... (Year)

7-AGE. ..... 54 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wesley Baker Slater

(Address)..... Bank of Mar Boardwalk

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month), ... 10 (Day), ... 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... Investigation ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Apoplexy .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Henry Ryan Asst Coroner ..... M. D.

Dec 10, 1917 (Address) ..... 1610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oaklawn

DATE OF BURIAL, 12/13, 19.7

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 ✓ D10791

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N. Mulberry ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Wakefield

(Residence in Baltimore: No. 904 N. Mulberry St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Mar (Month) 3 (Day) 1858 (Year)

7-AGE: 59 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Mathias Romoser

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Sarah Knud

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William C. Wakefield

(Address) 904 N. Mulberry St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-10-17 1917, to 12-10 1917, that I saw h... alive on 12-10 1917, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) ....yrs. 3 mos. ....ds.

(Signed) T. H. Phillips M. D.

....., 191... (Address) 1701 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 12-13, 191.

20-UNDERTAKER Chas. E. Evans & Son ADDRESS Lumbard Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 12 1917 ROBERT B. KRAUTER Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10792

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2616 Bruce Entrance St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Lindsay

(Residence in Baltimore: No. 2616 Bruce St.; yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 15, 1916 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country):

PARENTS.

10-NAME OF FATHER: Geo Lindsay Jr
11-BIRTHPLACE OF FATHER (State or Country): Balto Md
12-MAIDEN NAME OF MOTHER: Margaret Nash
13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Lindsay Jr
(Address) 2616 Bruce St

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suffocation (Accd)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Burns

(Duration)..... yrs..... mos..... ds.

(Signed) J. Wm Morrissey M. D. (Coroner.)

Dec 11 1917 (Address) 1632 Rutland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Mays Cemetery	Dec 12, 1917
20-UNDERTAKER J. E. W. Faulkner	ADDRESS 1634 Mt Ryot Ave

D10793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2616 Bruce Terrace ST.; 13 WARD)

REGISTERED No. C 168 D10793

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Raymond Lindsay

(Residence in Baltimore: No. 2616 Bruce Terrace St.; yrs. 4 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Sing

6-DATE OF BIRTH, July 18, 1913
(Month) (Day) (Year)

7-AGE, 4 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balt'o Md

PARENTS.

10-NAME OF FATHER, Geo Lindsay Jr

11-BIRTHPLACE OF FATHER (State or Country), Balt'o Md

12-MAIDEN NAME OF MOTHER, Margaret Nash

13-BIRTHPLACE OF MOTHER (State or Country), Balt'o Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Lindsay Jr
(Address) 2616 Bruce Terrace

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and from (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Morrison M. D.
Dec 11 1917 (Coroner) (Address) 1622 Robinson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER, W M Gawthrop — ADDRESS 1624 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10791

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D10791

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2616 Bruce & Fernce ST.: K 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Lundson

(Residence in Baltimore: No. 2616 Bruce & Fernce St.: yrs. 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: Oct 10, 1914 (Month) (Day) (Year)

7-AGE: 3 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: George A Lundson Jr

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Margaret Nash

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Lundson

(Address) 2616 Bruce & Fernce

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Dec 14 1917 (Address) 1632 Rolandre

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Ft Mcp's Hampden — DATE OF BURIAL: Dec 13, 1917

20-UNDERTAKER: [illegible] — ADDRESS: 1624 N. Regester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10795

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna L. Staff

(Residence in Baltimore: No. 1113 N. Bond St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: October 11th, 1883. (Month) (Day) (Year)

7-AGE: 34 yrs. 1 mos. 30 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Invalid

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Frederick Staff

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Margaret Guntman

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Staff

(Address) 1113 N. Bond St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: December 10th, 1917. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from October 9th, 191.., to December 10th, 1917, that I saw her alive on December 10th, 1917, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1.

Chronic Nephritis

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Frank H. A. Mey M. D.

Dec. 10th, 1917. (Address) 10 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Dec. 13., 1917.

20-UNDERTAKER: Henry Lutz

ADDRESS: 1007 N Bond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10796

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pronounced dead at Mercy Hospital St.: 1817 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Garrett

(Residence in Baltimore: No. 110 N. Shroeder St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 42 or 43 yrs. Estimated 43 yrs. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, N. Barrett

11-BIRTHPLACE OF FATHER (State or Country), N. C. (?)

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Bailey

(Address) 110 N. Shroeder

15-

Filed ....., 191.....

Registrar.

DEC 12 1917 ROBERT R. KRAUTER Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage. Broken skull

Caused by accidentally falling down stairs upon head

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 12, 1917 (Address) 1039 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Plymouth N. C. DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER Robt Turner ADDRESS 1112 N Broadway

D10797

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10797

50 ✓

1 PLACE OF DEATH Bellis or Fellowes Sanitarium — REGISTERED No. C

CITY OF BALTIMORE (No. 2724 N Charles St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Martha Walker Mockell

(Residence in Baltimore: No. 701 W Lafayette Ave St.; 10 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word): Married

6 DATE OF BIRTH: April (Month) 29, (Day) 1845 (Year)

7 AGE: 72 yrs. 8 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Johnson Walker

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary E Autrey

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy Maria Jones

(Address) 701 W Lafayette Ave

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 10 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1917, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 10 yrs. mos. ds

Contributory (SECONDARY) Carbuncle

(Duration) yrs. 11 mos. 12 ds.

(Signed) Jno F Fellowes M. D.

12/10, 1917 (Address) 2042 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Dec 13, 1917

20 UNDERTAKER: Clark & Johnson — ADDRESS: 1 W Saratoga

(Over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10793

CERTIFICATE OF DEATH.

D10793

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mrs General Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evans Wright

(Residence in Baltimore: No. 1322 Calhoun St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male. | 4-COLOR OR RACE, black | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Easton Shore md

PARENTS.

10-NAME OF FATHER, John Wright

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Wright

(Address) 1322 N Calhoun st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Nov 21 1917, to Dec 9 1917, that I saw him alive on Dec 9 1917, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M. D.

Dec 9, 1917 (Address) Mrs Generals Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 18 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1322 Calhoun St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER James H. Dennis | ADDRESS 1307 Preston

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10799

CERTIFICATE OF DEATH.

D10799

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 Lambert ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Johnson

(Residence in Baltimore: No. 534 Lambert St.; ..... yrs., 9 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colm

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Feb 20, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 9 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER, Thos Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Constance Smith

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Johnson

(Address) 543 Lambert St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Dec 7 1917, that I saw h[illegible] alive on Dec 6 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 11 ds.

(Signed) Edw Short M. D.

12-7-17, 191.. (Address) 1512 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ont Auburn Cem

DATE OF BURIAL, Dec 10, 191..

20-UNDERTAKER James H. Dennis

ADDRESS 1303 Pennsylvania

Spec.—8-24-14—M. & T.—2000 Bks.

D10800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10800

CERTIFICATE OF DEATH.

REGISTERED NO. C 15 - 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Forman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Gallery

(Residence in Baltimore: No. 1607 Forman St.; 4 yrs., mos. ds.)

31 yrs in city.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 2, 1863 (Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

243 040

9-BIRTHPLACE, (State or Country), Essex Co. Virginia

PARENTS.

10-NAME OF FATHER, Griffin Gallery

11-BIRTHPLACE OF FATHER (State or Country), New Orleans. Louisiana

12-MAIDEN NAME OF MOTHER Polly Byrd

13-BIRTHPLACE OF MOTHER (State or Country), Essex Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Gallery

(Address) 1607 Forman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 9, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1917, to Dec 9 1917, that I saw h[illegible] alive on Dec 9 1917, and that death occurred, on the date stated above, at 5.50 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 10 ds.

(Signed) Wm. T. Lusby M. D.

Dec. 9., 1917. (Address) 120 S. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cemetery DATE OF BURIAL, Dec. 12, 1917.

20-UNDERTAKER James H. Dennis ADDRESS 1303 Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER; WITH CREASING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10801

CERTIFICATE OF DEATH.

79 D10801

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 E Hoffman ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte A. Theil

(Residence in Baltimore: No. 2204 E Hoffman St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Nov 28, 1839
(Month) (Day) (Year)

7-AGE, 78 yrs. — mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rose Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Theil

(Address) 2204 E Hoffman

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Dec 11 1917, that I saw her alive on Dec 10 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) B O Herzog M. D.

Dec 11, 1917. (Address) 1305 N Patterson Pk Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Dec 13 1917

20-UNDERTAKER Philip Henry — ADDRESS 206 Allen

DEC 12 1917 ROBERT R. CRAWFORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PEARL, WITH CANADIAN INK—THIS IS A PERMANENT RECORD

Jane N. Gough

D10802 17 — A10802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 N Eutaw St.; 17 WARD)

2-FULL NAME Janeretta Gough (Gough)

(Residence in Baltimore: No. 526 N Eutaw St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. June mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer). Myself

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D E Mollohan

(Address) 819 N Eutaw

15-

DEC 12 1917 — BERTIE W. BRADTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Asphyxiation
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Watkins M. D.
(Coroner.)

....., 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Dec. 12, 1917

20-UNDERTAKER Chas. E. Franck — ADDRESS 802 Madison Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10803

CERTIFICATE OF DEATH.

151 D10803

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Curtis

(Residence in Baltimore: No. ..... St.: ..... yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, 12 (Month) — 5 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. 11 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work V
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Curtis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Cornelia Grunwell

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 9 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 5 — 191 7, to Dec 9 — 191 7, that I saw him alive on Dec 5 — 191 7, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

..... Exhaustion from Marasmus .....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

..... (Duration) .... yrs. .... mos. .... ds.

(Signed) ..... L. W. Douglass M. D.

12/9, 191 7. (Address) Municipal Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 12 1917 ROBERT R. REVERE Commissioner Health.

15837

Spec.—8-24-14—M. & T.—2000 Bks.

Bessie Astrinsky 79

D10807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Eden ST.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Astrinsky

(Residence in Baltimore: No. 206 N. Eden St. St.: 12 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	married

6-DATE OF BIRTH, January 1 (Month) (Day) 1897 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. 11 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Want

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Clara

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Lewis

(Address) 1411 E. Baltimore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1915, to Dec 12 1917, that I saw her alive on Dec 13 1917, and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

..... (Duration) ? yrs. ? mos. ? ds.

(Signed) M. X Baylin M. D.

Dec 12, 1917. (Address) 712 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	12 14, 1917

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10805

D10805

£150

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bailey

(Residence in Baltimore: No. 26 days (Johns Hopkin Hosp.) St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, January 25, 1908
(Month) (Day) (Year)

7-AGE, 9 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), ?

PARENTS.

10-NAME OF FATHER, Frank Bailey

11-BIRTHPLACE OF FATHER (State or Country), Minn.

12-MAIDEN NAME OF MOTHER Annie

13-BIRTHPLACE OF MOTHER (State or Country), Minn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 8, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 13 1917, to Dec 8 1917, that I saw her alive on December 8 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion of bladder

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

(Signed) H. [illegible] M. D.

Dec 8, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 26 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ~

Former or usual residence Jacksonville, Florida

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ft Comfort Cem	Dec 13, 1917.
20-UNDERTAKER Albert E. Leslie	ADDRESS 2201 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10806

CERTIFICATE OF DEATH.

D10806

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.; 2 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Erickson

(Residence in Baltimore: No. Windsor Hotel ST.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November 22, 1876
(Month) (Day) (Year)

7-AGE, 39 yrs. 16 mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Sweden

PARENTS.

10-NAME OF FATHER, Carl

11-BIRTHPLACE OF FATHER (State or Country) Sweden

12-MAIDEN NAME OF MOTHER Helena Ronston

13-BIRTHPLACE OF MOTHER (State or Country) Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Johns Hopkins Hospital

15-

Filed ....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 9 1917, that I saw h[illegible] alive on December 9 1917, and that death occurred, on the date stated above, at 6.35 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Collapse

(Duration) yrs. mos. 1 ds.

(Signed) C. H. Bloomfield M. D.

Dec 9, 191[illegible] (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death [illegible] yrs. [illegible] mos. 4 ds. In the State [illegible] yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10807

CERTIFICATE OF DEATH.

1917 D10807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Ellen Edwards Ave) (Ward 12) REGISTERED No. C

2-FULL NAME James Freeley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1860 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 04-0

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER Joseph Freeley

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Colasuta

(Address) 422 Ellen Edwards Ave

15-

Filed ....., 191..... C. Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Dec 11 1917, that I saw h[illegible] alive on Dec 11 1917, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe Grossnickle M. D.

Dec 11 1917 (Address) 1138 Ellen Edwards Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St Vincent DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER H F Marshall ADDRESS 853 Wolfe St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10808 D10808

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Fawn ST.; 3d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelo Deiccia

(Residence in Baltimore: No. 919 Fawn St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHILE PERMIT, WITH CERTIFICATE, IS THE PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 3, 1917
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Nicholas Deiccia

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Raffel Deiccia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raffel Deiccia

(Address) 919 Fawn

15-

Filed ....., 191.....

Registrar.

B.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1917, to Dec. 12, 1917, that I saw him alive on Dec. 11, 1917, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Six months miscarriage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Eugene L. Pessagno M. D.

Dec. 12, 1917. (Address) 2314 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
H Vincent	Dec. 12, 1917
20-UNDERTAKER Wendell Whitfield & Son	ADDRESS 378 Fawn

Spec.—8-24-14—M. & T.—2000 Blks.

D10809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10809

CERTIFICATE OF DEATH.

43

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 W. Lafayette ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Mae Bridal

(Residence in Baltimore: No. 1427 W. Lafayette St.; 39 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Married

6-DATE OF BIRTH. ..... July (Month) 25 (Day), 1917 (Year)

7-AGE. 38 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At home

9-BIRTHPLACE. (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. H. Russell

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Wain

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Fordal

(Address) 1427 W. Lafayette Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 2 1917, to Dec 12 1917, that I saw h-r alive on Dec 12 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) general carcinosis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) H. C. Kruft M. D.

Dec 12, 1917 (Address) 100 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Dec 14, 1917.

20-UNDERTAKER Geo W Little — ADDRESS 531 N Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10810

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E Barney ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Sellers

(Residence in Baltimore: No. 13 E Barney St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ...35....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 63.

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Jacob Krauss

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Belschner

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celeste Sellers

(Address) 13 E. Barney

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 191.7 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ....yrs....mos....1..ds.

CONTRIBUTORY (Secondary) Convulsions

..... (Duration) ....yrs....mos....1..ds.

(Signed) R. C. Campbell M. D.

Dec 10, 1917 (Address) 1604 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Dec 12, 191...
20-UNDERTAKER	ADDRESS
E J Lannigan	1410 Bolton Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10811

CERTIFICATE OF DEATH.

D10811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Walbrook Ave ST.; 15 WARD)

REGISTERED No. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Schultze

(Residence in Baltimore: No. 1812 Walbrook Ave St.; ....yrs.,.... mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb. (Month) 17 (Day), 1829 (Year)

7-AGE, 88 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer): no

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frederick Davis

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Sarah Johnston

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs I. Rose

(Address) 1812 Walbrook Ave

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 2 1917, to Dec 10 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as followa: Cerebral Anaemia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Asthenia

(Duration) 2 yrs. (?) mos. ....ds.

(Signed) [illegible] M. D.

12/10, 1917 (Address) 1812 Walbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oak Hill D.C.	Dec 14 1917
20-UNDERTAKER	ADDRESS
M Lean Jones	833 Linden Ave

D10812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10812

1-PLACE OF DEATH Pronounced dead at Franklin Square Hospital 170 Registered No. C

CITY OF BALTIMORE (No. 21 St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ossenkemper

(Residence in Baltimore: No. 1235 James St. St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: July (Month) 29 (Day), 1874 (Year)

7-AGE: 43 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Iron Foundry

PARENTS.

9-BIRTHPLACE, (State or Country): Germany

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henriette Ossenkemper

(Address) 816 Hanover St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Congestion of Lungs

Odema of Brain (Duration) Sudden yrs. mos. ds.

(Signed) James M Hanson M. D. (Coroner.)

Dec. 12, 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: Dec. 15th 1917

20-UNDERTAKER: Chas. H. Dill. ADDRESS: 3609 Frederick Ave.

D10813 HEALTH DEPARTMENT—CITY OF BALTIMORE D10813

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1602 Eager St.; 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Harry & Jennie Thomas

(Residence in Baltimore: No. 1602 Eager St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Boy

6-DATE OF BIRTH, Dec 11, 17
(Month) (Day) (Year)

7-AGE. ...yrs...mos...1...ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Harry Thomas

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Jennie Mother

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Thomas

(Address) 1602 Eager

15-

DEC 13 1917 ROBERT P. KRAUTER REGISTRAR OF VITAL STATISTICS

Filed..., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) J. Wm. Hales M. D.
(Coroner.)

..., 191.. (Address) 1 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Dec 13, 19..
20-UNDERTAKER Henry Lutz	ADDRESS 1007 N Broad St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10817 D10814

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Clarkson ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Trumbo

(Residence in Baltimore: No. 1424 Clarkson St.; 1 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. (Month) 12 (Day), 1852 (Year)

7-AGE, 95 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md. Balto

PARENTS.

10-NAME OF FATHER, Andrew J. Trumbo

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Matilda Say

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mos. Trumbo

(Address) 1424 Clarkson

15-

DEC 13 1917 SOPHIE S. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 12 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) J. F. Hartman M. D.

12/13, 191[illegible]. (Address) 19 Randall Ln

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, M. Olivet.

DATE OF BURIAL, 12/15, 191[illegible]7.

20-UNDERTAKER J. Frew Mitchell

ADDRESS 100 E. Fort

Spec.—5-19-13—M. & T.—500 Bks.

D10815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10815

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 34 E. Barney ST.; 23 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out (No. 18.)

2-FULL NAME Louis H. Steinbock

(Residence in Baltimore: No. 34 E. Barney St.: Yrs. 7 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan (Month) 4 (Day), 1888 (Year)

7-AGE, 29 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumbers
(b) General nature of industry, business, or establishment in which employed (or employer): Helper.

9-BIRTHPLACE, (State or Country), Md. Balto

PARENTS.

10-NAME OF FATHER, Wm. Steinbock

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lena Huth

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Steinbock

(Address) 34 E. Barney

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 11 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 10:37 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation complicated

.....

.....

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

(Signed) J. L. Haus Penn M. D.

12/13, 1917 (Address) 1 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk

DATE OF BURIAL, 12/14, 1917

20-UNDERTAKER J. Frank McCully

ADDRESS 130 E. Fort

Rosa Queen

HEALTH DEPARTMENT—CITY OF BALTIMORE

17 & 0 D10816 — D10816 — 79

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1207 St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Queen

(Residence in Baltimore: No. 1207 St.: 70 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR ~~RACE~~, colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, January, 1837 (Month) (Day) (Year)

7-AGE, 80 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Own home

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Queen

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Queen

(Address) 1207 Biddle St.

15-

Filed....., 191.....

Registrar.

DEC 13 1917 ROBERT B. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) J. Whitehorne M. D. (Coroner.)

Dec 12, 191 (Address) 5 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral cemetery

DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER Joseph A. Frick

ADDRESS 2319 Division

Henry H. Colton

D10817.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10817.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Le Dept. Hospitals St.; 8 WARD) REGISTERED No. C 175

2-FULL NAME Henry H. Colton.

(Residence in Baltimore: No. 1632 Maryland St., 75 St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Nov (Month) 2 (Day), 1842 (Year)

7-AGE, 70 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butter Buyer
(b) General nature of industry, business, or establishment in which employed (or employer): Dairy

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, William Colton

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hedwig J. Colton

(Address) 1632 Maryland

15-

Filed DEC 13 1917, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Acute Endocarditis
Cardiac Failure

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] (Coroner.) M. D.

Dec. 12, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER Robt. E. Turnbull — ADDRESS 1472 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10818

CERTIFICATE OF DEATH.

D10818

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 E Heath ST.; 24 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Fitzpatrick

(Residence in Baltimore: No. 221 E Heath St.; 51 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 22, 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House wife
(b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Phillips

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Forton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos F. Fitzpatrick

(Address) W. Lexington St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1913, to Dec 10 1917, that I saw her alive on Dec 9 1917, and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Chronic erysipelatous infection, multiple abscess and septic infection

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple abscesses

(Duration) 3 yrs. mos. ds.

(Signed) Neil Stipe M. D.

12/11, 1917. (Address) 1319 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Cem. DATE OF BURIAL, DEC 13, 1917

20-UNDERTAKER Thos F. Fahey & Sons ADDRESS 1318 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10819 — 81 ✓ — D10819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia O'Mara

(Residence in Baltimore: No. 945 Hallum St — St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. Unknown ....., 1852
(Month) (Day) (Year)

7-AGE. 65 yrs. mos. ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Daniel O'Mara

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Mary Gill

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12 th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No Record 191, to 191, that I saw h[er] alive on Dec 9 1917, and that death occurred, on the date stated above, at 945 a.m.

The CAUSE OF DEATH* was as follows:

.....

Arteria Sclerosis

Unknown (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Dufation) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

Dec 12, 1917. (Address) 1133 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. 8 mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Peters Cem	Dec 15th 1917

20-UNDERTAKER	ADDRESS
John J. Noonan & Son	901 Hallum St

DEC 13 1917 — REGISTRAR'S OFFICE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PEARL, WHITE CRACKING INK — THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Sarah J. Kitson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10820 / 120 / D10820

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Sydenham ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J. Kitson

(Residence in Baltimore: No. 8 Sydenham St.; abt 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Oct 27, 1867 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
47 yrs. 1 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer): Work, Home

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, John Burdett,

11-BIRTHPLACE OF FATHER (State or Country), ~~Ky.~~ England.

12-MAIDEN NAME OF MOTHER Marks

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nelson

(Address) 1420 Hanover

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 191., to Dec 10 191., that I saw h alive on Dec 7 191., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Exhaustion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.

Dec 10, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Stemmers Baptist Cemetery

DATE OF BURIAL, Dec. 13th, 191..

20-UNDERTAKER George F. Ruth

ADDRESS 735 Hanford Ave.

N. B.—Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10821

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D10821

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Bruce ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Hubert

(Residence in Baltimore: No. 1029 Bruce St.; Life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Married

6-DATE OF BIRTH April (Month) 12 (Day) 1886 (Year)

7-AGE 31 yrs. 7 mos. 23 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER Henry Mueller

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Lotz

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William E. Hubert

(Address) 1102 Russell

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11, 1917, to Dec 12 1917, that I saw h.r alive on Dec 11 1917, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Throat and Lungs.

(Duration) 10 yrs 7 mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed), Reginald S. Glenn M. D.

Dec 13 1917 [Address] 1st Mercantile

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Dec. 15th 1917.

20-UNDERTAKER E. Schlosman & Son ADDRESS 1039 Hanover St.

Spec.—5-19-15—M. & T.—500 Blks.

D10822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10822

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3806 Elm Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madeline Tracy

(Residence in Baltimore: No. 3806 Elm Ave St., 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH. May (Month) 24 (Day), 1871 (Year)

7-AGE. 46 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Christopher J. Tanner

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary J. Earle

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. D. Tracey

(Address) 3806 Elm Ave

15-

Filed....., 191.... Registrar.

DEC 13 1917 ROBERT B. FRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. (Month) 11. (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1917, to Dec 11 1917, that I saw h[er] alive on Dec 11 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ....

(Duration) yrs. mos. ds.

(Signed) E. Evans M. D.

Dec 12, 1917. (Address) 865 W. 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Mary's Hampden

DATE OF BURIAL. Dec. 15., 1917.

20-UNDERTAKER Horace Burgee & Son

ADDRESS 363 Falls Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10823

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rhand Yorkinfan

(Residence in Baltimore: No. 318 N Ann St St.; 7yr yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 28, 1887 (Month) (Day) (Year)

7-AGE, 30 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Balto - Maryland

PARENTS.

10-NAME OF FATHER, Sam Dudley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catherine Danby

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C F Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 9 191 7 to Dec 11 191 7, that I saw her alive on Dec 11 191 7, and that death occurred, on the date stated above, at 11.42 m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

..... (Duration)..... yrs..... mos..... ds.

(Signed) C. F. Bloomfield M. D.

Dec 11, 191 7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 318 N Ann St

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetary — DATE OF BURIAL, Dec 14th, 1917

20-UNDERTAKER Chas G Bailey — ADDRESS 1421 Jefferson St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10821

CERTIFICATE OF DEATH.

29 ✓ D10821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt L. Hamill

(Residence in Baltimore: No. 912 N. Franklin St. 30 yrs. 9 mos. 3 ds.)

P

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb. 10, 1887 (Month) (Day) (Year)

7-AGE, 30 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): " 609

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robt. Hamill

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hilton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Hamill Jr

(Address) Mercy Hosp

15-

Filed.....; 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 191 , to Dec 12 1917 , that I saw him alive on Dec 2 1917 , and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(Duration) Days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward H. Hamill M. D.

Dec 13, 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. 2 mos. ds.

Where was disease contracted, if not at place of death? 912 N. Franklin

Former or usual residence 912 N. Franklin St.

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER Chas. J. Tellis ADDRESS 1631 E. Baltimore

DEC 13 1917 REGISTRAR R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D10825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10825

CERTIFICATE OF DEATH.

40

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Santa

(Residence in Baltimore: No. 517 N. Chapel St.; 25 yrs,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 50 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Santo

(Address) 517 N Chapel St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 12 1917, and that death occurred, on the date stated above, at 245 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

..... (Duration) .....yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) W. Thomson M. D.

Dec 7, 1917 (Address) 720 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill	Dec 15, 1917
20-UNDERTAKER	ADDRESS
Frank Enoch & Son	1900 W. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Herbert Robinson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10826

CERTIFICATE OF DEATH.

D10826

REGISTERED No. C 53

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; H6SP WARD)

2-FULL NAME Herbert Robinson

(Residence in Baltimore: No. 101 N. East Ave Balt. Md. St.; (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs. Life mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 26, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Hyman Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Pauline Hurling

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 12 1917, and that death occurred, on the date stated above, at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Acute Leukemia

(Duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary) D.

(Duration) yrs. mos. ds.

(Signed) A. M. Barnes M. D.

Dec 12, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 21 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 101 N East Ave

19-PLACE OF BURIAL OR REMOVAL. Hebrew Belvue Cem

DATE OF BURIAL, Dec 13, 1917.

20-UNDERTAKER Joseph Levin

ADDRESS 1411 E Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D10827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10827.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Kelley

(Residence in Baltimore: No. 2217 Preston Place St.; 10 yrs., ... mos., ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1897 (Year)

7-AGE, 20 yrs. 6 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machine Feeder
(b) General nature of industry, business, or establishment in which employed (or employer): Glass

9-BIRTHPLACE. (State or Country), Bedford Co Pa

PARENTS.

10-NAME OF FATHER, Michael Bartgis

11-BIRTHPLACE OF FATHER (State or Country), Bedford Co Pa

12-MAIDEN NAME OF MOTHER Martha Miller

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael J. Bartgis (Father)

(Address) W. Va.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 191 7, to Dec 11 191 7, that I saw h.. alive on Dec 11 191 7, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tubercular Enteritis

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) ..... M. D.

Dec 11, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 19 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 2217 Preston Place

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL. Dec 14..., 1917

20-UNDERTAKER, James Dignan & Son

ADDRESS 1200 S. Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

D10823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D10823

REGISTERED No. C.....

1-PLACE OF DEATH St Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jones Marion Kesler

(Residence in Baltimore: No. 1401 Division St.; yrs., 3 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Wht	Single

6-DATE OF BIRTH, Aug 15, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

850

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Ada Kesler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St Vincents

(Address) 1401 Division St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec, 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1917, to Dec 10 1917, that I saw h.. alive on Dec 9, 1917, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) ...yrs. 3 mos. ...ds.

CONTRIBUTORY (Secondary) Bathe Fed

..... (Duration) ...yrs. 3 mos. ...ds.

(Signed) Lyman in C. Tarbell M. D.

....., 191... (Address) 825 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. 3 mos. 28 ds. In the State ...yrs. 3 mos. 28 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence None

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, Dec. 13, 1917.

20-UNDERTAKER M Fraher & Sons ADDRESS 601 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10829

CERTIFICATE OF DEATH.

108 D10829

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Fitzgerald

(Residence in Baltimore: No. 1606 N. Gilmore St St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 14, 1905
(Month) (Day) (Year)

7-AGE, 12 yrs. 1 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Fitzgerald

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret O'Connell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Fitzgerald

(Address) 1606 N. Gilmore St

15-

DEC 13 1917 ROBERT P. BRAUER

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1917, to Dec 13 1917, that I saw him alive on Dec 13 1917, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about (Duration) ....yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Purulent Nephritis

Ruptured Tonsil Nov 15 17

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward L. Smith M. D.

Dec 13, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 14 ds. In the State 12 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1606 N. Gilmore St

Former or usual residence 1606 N. Gilmore St

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Dec. 15, 1917.

20-UNDERTAKER Martin Fahey Sons ADDRESS 606 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10830

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10830

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Callow Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip R Berger

(Residence in Baltimore: No. 2310 Callow Ave

Age: 76 yrs., 4 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ Married (Write the word.)

6-DATE OF BIRTH, Aug. (Month) 10th (Day), 1841. (Year)

7-AGE, 76 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Sergeant
(b) General nature of industry, business, or establishment in which employed (or employer): of Police

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Christian Berger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Kneass

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R E L Berger

(Address) 2530 Maryland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1917, to Dec 12th 1917, that I saw him alive on Dec 11th 1917, and that death occurred, on the date stated above, at 5.00 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....Myocarditis & Degeneration of Kidneys

.....Myocarditis..... (Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) C. W. Mitchell M. D.

Dec 12, 1917. (Address) 9 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER Bertrand Yost — ADDRESS 1723 W Lafayette Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 ✓ D10831

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 21 Joseph Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mellie Banks

(Residence in Baltimore: No. 1006 Durham, St.; yrs., 1yr mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mat

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, Nov 27, 1914
(Month) (Day) (Year)

7-AGE, 4 yrs. — mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... Bds

9-BIRTHPLACE, (State or Country), Balto,

PARENTS.

10-NAME OF FATHER, Richard Banks,

11-BIRTHPLACE OF FATHER (State or Country). Va,

12-MAIDEN NAME OF MOTHER Rosa Brown

13-BIRTHPLACE OF MOTHER (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Banks,

(Address) 1006 Durham,

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns: accidental
shot: Pistol Ball
Lung: Socket of Left

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 12, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER Samuel T Hawley

ADDRESS 578 W Balto

17
2
4 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10832

CERTIFICATE OF DEATH.

167 D10832

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Md. Gen'l Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anneetta Johnson

(Residence in Baltimore: No. 1908 Druid Hill Ave St.; yrs. 50 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 184+ (Year)

7-AGE, ... 75 ..... yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeping House

9-BIRTHPLACE, (State or Country), Va (Va)

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Margaret Woodson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Stewart

(Address) 1908 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

DEC 13 1917 ROBERT B. FRAUTEN Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917
..... (Month) ..... (Day) ..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns
of Body
Shock
Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Dec 13, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 13th, 1917

20-UNDERTAKER, David T Hunter — ADDRESS, 578 N Bond

Spec.—8-24-14—M. & T.—2000 Blks.

D10833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10833

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Sarah Ann St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tilda Bromley

(Residence in Baltimore: No. 604 Sarah Ann St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, ..., 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Alonzo Bromley

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Augusta Day

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angel Bromley

(Address) 513 N. Bradford St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 11 1917, that I saw her alive on Dec 11 1917, and that death occurred, on the date stated above, at 3 40 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs....mos....ds.

(Signed) E. H. Bartlett M. D.

12/11, 191.7 (Address) 1727 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 12/13, 191.7

20-UNDERTAKER Samuel T. Hemsley

ADDRESS 578 N. Bradford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-10-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10834

CERTIFICATE OF DEATH.

28 D10834

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 400 Wormsley ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Brightman

(Residence in Baltimore: No. 400 Wormsley St.; 31 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	widower

6-DATE OF BIRTH, March ....., 1858
(Month) (Day) (Year)

7-AGE, 49 yrs. 8 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labour
(b) General nature of industry, business, or establishment in which employed (or employer)..... Driver 023

9-BIRTHPLACE, (State or Country), New Market Frederick Co

PARENTS.

10-NAME OF FATHER, Dennis Brightman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Howard

13-BIRTHPLACE OF MOTHER (State or Country), New Market Frederick Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry E. Brightman

(Address) 226 McCulloh St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3rd 1917, to Dec 11th 1917, that I saw h alive on Dec 11th 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Heart failure

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Reginald J Lowry M. D.

Dec 12, 1917 (Address) 414 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER Samuel T Hemsley ADDRESS 578 N Bond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10835

CERTIFICATE OF DEATH.

40 D10835

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 973 Lemmon ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Lechler

(Residence in Baltimore: No. 973 Lemmon St.: 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Widow

6-DATE OF BIRTH, December 4th, 1875
(Month) (Day) (Year)

7-AGE, 41 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Frederick Co. Maryland

PARENTS.

10-NAME OF FATHER, George Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER — Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edmon Block M.D.

(Address) 703 Hamilton Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13, 1917, to December 14th, 1917, that I saw ~~her~~ alive on December 14th 1917, and that death occurred, on the date stated above, at 5.9 m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of the Breast with secondary Nodes in Axilla

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) Edmon Block M. D.

Dec 15, 191.7 (Address) 703 Hamilton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos ds

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec. 15, 191.7

20-UNDERTAKER Jos. Block — ADDRESS 703 Balto St

DEC 13 1917 ROBERT R. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10836 D10836

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2520 Colvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Hilgeman

(Residence in Baltimore: No. 2520 Colvert St.) S. 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Dec. 5, 1856 (Month) (Day) (Year)

7-AGE: 61 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Co Md

PARENTS.

10-NAME OF FATHER: Andrew Kluiedust

11-BIRTHPLACE OF FATHER (State or Country): Carroll Co Md

12-MAIDEN NAME OF MOTHER: Isabelle Price

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Hilgeman

(Address) 2520 N. Colvert St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 11, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, Autopsy or inquiry.) find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) John Hilgeman M.D.

(Date) Dec 14 191 7 (Address) 2632 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL, Dec 14th 1917

20-UNDERTAKER: Joseph F. Cook ADDRESS 1003 N. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D10837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D10837

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 O Smallwood ST.; 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna E Taylor

(Residence in Baltimore: No. 440 O Smallwood St.; 65 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the Word.)
Female	White	Widowed

6-DATE OF BIRTH, June (Month) 10th (Day), 1837 (Year)

7-AGE	If LESS than 1 day,
80 yrs. 6 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER, John Curtis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Orme

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert R Taylor

(Address) 1816 N Mulberry St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1917, to Dec 12th 1917, that I saw her alive on Dec 12th 1917, and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(Duration) ... yrs. ... mos. ... ds.

(Signed) Albert R. Mortimer M. D.

Dec 12th 1917 (Address) 532 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER P P Bloch — ADDRESS 1003 W Baltimore St

N. B.—Every item of information should be carefully supplied. ACCURACY of AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10833

CERTIFICATE OF DEATH.

64 D10833

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2839 Rayner av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Harry Filbert -

(Residence in Baltimore: No. 2839 Rayner av) St.; 51 yrs., mos. 11 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1866 (Year)

7-AGE, 51 yrs. — mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Filbert -

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Daub -

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Filbert

(Address) 2839 Rayner av

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 12 1917, that I saw him alive on Dec 12 1917, and that death occurred, on the date stated above, at 8,00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) W K Jamison M. D.

Dec 13 191... (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 15, 191...

20-UNDERTAKER Jr. B Cook ADDRESS 1003 W Balt

DEC 13 1917 ROBERT R. KRAUTER

Spec.—5-19-13—M. & T.—500 Bks.

D10839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10839

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 3001 Independence) ST.: ..... WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levin W. Jenkins

(Residence in Baltimore: No. 3001 Independence St.) St.: 73 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: the Statistical CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 1, 1831
(Month) (Day) (Year)

7-AGE, 86 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Rockbridge Co Va

PARENTS.

10-NAME OF FATHER, Henry Jenkins

11-BIRTHPLACE OF FATHER (State or Country), Rockbridge Co Va

12-MAIDEN NAME OF MOTHER Ann Lee

13-BIRTHPLACE OF MOTHER (State or Country), Rockbridge Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie J. Jenkins

(Address) 3001 Independence St.

15-

Filed DEC 13 1917, 191

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 15th 1917, to Dec 11th 1917, that I saw h[illegible] alive on Dec 10 1917, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) 1 yrs. 10 mos. 5 ds.

(Signed) W. H. Fleet M. D.

Dec 13 191 (Address) 1216 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, OKDAR HILL. DATE OF BURIAL, DEC. 14 1917

20-UNDERTAKER ARMSTRONG-DENNY CO. ADDRESS 715 Light

D10840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10840

CERTIFICATE OF DEATH.

+166

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital St. 4 WARD)
2-FULL NAME Frank Gaiden "Gowan"
(Residence in Baltimore: No. Edgewood Hartford Co. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1845.
(Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm hand.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Probably Maryland.

PARENTS.

10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country), Unknown
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) University Hospital Records
(Address) Green & Lombard Sts

15-
Filed....., 191.....
Registrar.

DEC 13 1917
ROBERT R. KRAUTER
REGISTRAR VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following burns Caused by house catching fire (accidental)

(Duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Friedell M. D.
(Coroner)
Dec 11, 1917. (Address) 1211 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place University Hospital in the of death ..... yrs. ..... mos. 7 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mon Cathedral — DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER Wm Cook — ADDRESS 207 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10811

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital ST.; WARD)

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Elmer Turner

(Residence in Baltimore: No. U. S. Marine Hospital St.; yrs., 2 mos. (8 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH ONFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1893
(Month) (Day) (Year)

7-AGE, 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record Surgeon

(Address) U. S. Marine Hospital

15-

Filed ....., 191.....

Registrar. B.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 24 1917, to Dec 12 1917, that I saw him alive on Dec 12 1917, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows: Valvular disease of heart Aortic regurgitation, Mitral regurgitation & Stenosis (Duration) yrs. 3 mos. 18 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion & Oedema (Duration) yrs. mos. 3 ds.

(Signed) J. H. Carter M. D.

Dec 12th, 1917 (Address) U. S. Marine Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence ?

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 13, 1917

20-UNDERTAKER Ellsworth & Son ADDRESS 367 Eutaw Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D10812

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3639 Dorsey Lane ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Koerber

(Residence in Baltimore: No. 3639 Dorsey Lane St.; 17 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 1 (Month) 31 (Day), 1895 (Year)

7-AGE, 22 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Koerber

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Virginia Bardoff

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Koerber

(Address) 3634 Dorsey Lane

15-

Filed....., 191.....

13. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 11 (Day), 11, 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1917, to Dec 11 1917, that I saw h[illegible] alive on Dec. 11 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Acute

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) Henry Stahr M. D.

Dec 13, 1917. (Address) 508 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 12-14, 1917

20-UNDERTAKER H. C. Baumgardner — ADDRESS 514 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Bks.

D10843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10843

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 W. Saratoga ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara B. Constable

(Residence in Baltimore: No. 1817 W. Saratoga St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feby. (Month) 25, (Day) 1863 (Year)

7-AGE, 54 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Port Deposit Md

PARENTS.

10-NAME OF FATHER. John A Mitchell

11-BIRTHPLACE OF FATHER (State or Country). Havre de Grace Md.

12-MAIDEN NAME OF MOTHER Adilia White

13-BIRTHPLACE OF MOTHER (State or Country). Port Deposit Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Ray Mayhall

(Address) 1817 W. Saratoga St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/3/1917, to 12/12 1917, that I saw her alive on 12/12 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexia

Left hemiplegia

..... (Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. 3 ds.

(Signed) [illegible] M. D.

12/12, 191.7 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hope Hall Cem. Co. DATE OF BURIAL, Dec 13 1917, 191...

20-UNDERTAKER W. B. Cook ADDRESS 501 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10811 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D10811

CERTIFICATE OF DEATH.

REGISTERED NO. C 150

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 503 W. Lombard St.; 4 WARD)
2-FULL NAME Infant of Lyle & Ida Knickman
(Residence in Baltimore: No. 503 W. Lombard St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, December 12, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.
10-NAME OF FATHER, Lyle V. Knickman
11-BIRTHPLACE OF FATHER (State or Country), Maryland.
12-MAIDEN NAME OF MOTHER Ida May Boyle
13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ida Murray
(Address) 501 W. Lombard St

15-
Filed ....., 191.... Registrar.
DEC 13 1917 ROBERT R. KRAUTER Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Congenital Cardiac Malformation
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) A. D. Driscoll M. D.
(Coroner) Dec 13, 1917. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bolton Cem.	12/14, 1917
20-UNDERTAKER	ADDRESS
Jos. B. Cook	1021 W. Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

D10845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D10845

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 64 Gorman Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Ruppel

(Residence in Baltimore: No. 64 Gorman av St.; 60 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 10., 1862
(Month) (Day) (Year)

7-AGE, 55 yrs. 0 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Carl Ruppel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Regina Stell.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. S. Ruppel

(Address) 54 Gorman Ave

15-

Filed ....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22. 1917, to Dec 12 1917, that I saw h[illegible] alive on Oct. 11. 1917, and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. V. Wilson M. D.

Dec 13., 1917. (Address) 1730 O'Hara St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Dec 14., 191[illegible]

20-UNDERTAKER Mrs. A. Rohde & Son

ADDRESS 730 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10816

CERTIFICATE OF DEATH.

29 ✓ D10816

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2545 McCulloh ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Davidson

(Residence in Baltimore: No. 2545 McCulloh St.: 27 yrs., — mos., — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 50 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham H Einstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dora Diskel

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Davidson

(Address) 2545 McCulloh St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 10, 1917, to Dec, 12 1917, that I saw her alive on Dec, 12, 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

..... (Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myo-Carditis (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Dan Drasnin M. D.

12/13..., 1917 (Address) 122 W Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 2545 McCulloh St

19-PLACE OF BURIAL OR REMOVAL Hebrew Washington — DATE OF BURIAL. Dec 14, 1917

20-UNDERTAKER A. Eisenberg & Bro — ADDRESS 1137 E Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D10817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp St.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Knipp

(Residence in Baltimore: No. 223 Cove St. St.; 31 yrs., 8 mos. 21 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	mgd

6-DATE OF BIRTH, March 22, 1886 (Month) (Day) (Year)

7-AGE	If LESS than 1 day,
31 yrs. 8 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd 223

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Knipp

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Dora Rehbold

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Knipp

(Address) 223 Cove St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10—1917, to Dec 13 1917, that I saw ~~him~~ alive on Dec 13 1917, and that death occurred, on the date stated above, at 5-20 p.m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia - pneumonia (septicaemia) (?)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. mos. 1 ds.

(Signed) Benj M Ely M. D.

Dec 13, 1917 (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 223 Cove St

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Dec 15, 1917

20-UNDERTAKER Thos A Robertson ADDRESS 730 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10848

CERTIFICATE OF DEATH.

D10813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Bolton St.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha McDougall Pope

(Residence in Baltimore: No. 1834 Bolton St.; 75 yrs., 2 mos., 2 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Int'd 5-201

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. September 11, 1836 (Month) (Day) (Year)

7-AGE. 81 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Louis Rice

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Rosanna Baker

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Martha C. Pope

(Address) 1834 Bolton Street

15-

Filed....., 191.....

DEC 11 1917 ROBERT B. KRAUTER
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 14 1917, that I saw h[illegible] alive on Dec 13 1917, and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Julian Thomas M. D.

....., 191... (Address) 3350 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Frederick City Md. | DATE OF BURIAL, Dec 16, 1917.

20-UNDERTAKER Stewart & Mowen Co. | ADDRESS 108 W. Mulberry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10849

REGISTERED No. C 91 D10849

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 424 Lewis St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua. Blye

(Residence in Baltimore: No. 424 Lewis St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Boy

6-DATE OF BIRTH, Oct 26, 15
(Month) (Day) (Year)

7-AGE, yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Caesar Blye

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mike Mooney

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caesar Blye

(Address) 424 Lewis

15- DEC 14 1917 ROBERT R. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Exam
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Exam
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Grip Pneu

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER Mrs. J. J. Locke ADDRESS 1302 Jefferson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10850

CERTIFICATE OF DEATH.

79 D10850

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S Bradford ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kunigunda Mueller

(Residence in Baltimore: No. 607 S Bradford St.; 53 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec (Month) 8 (Day), 1846 (Year)

7-AGE, 71 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Elizabeth Mueller

(Address) 607 S Bradford St

15-

Filed....., 191.....

Registrar.

DEC 11 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-4 1917, to 12-11 1917, that I saw h[illegible] alive on 12-11 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmon[illegible] Carcinoma

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Albert Mueller M. D.

12/14/17, 191.7. (Address) 2237 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Dec. 15., 1917.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10851

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 W. Mt Royal ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Ellis

(Residence in Baltimore: No. 100 W. Mt Royal ave St.; 71 yrs., 10 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June 3, 1896
(Month) (Day) (Year)

7-AGE, 21 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Ofc

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Burnet Ellis

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rizzie Myers

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Ellis

(Address) 617 N. Gilmor st

15-

Filed....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 28 1917, to Dec. 13 1917, that I saw him alive on Dec. 13 1917, and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Laryngeal (Pulmonary (Gastro-Intestinal

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Tuberculosis

(Duration) yrs. mos. 14 ds.

(Signed) Arthur L. Barnes M. D.

12 14, 191... (Address) 1621 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	....., 191...
20-UNDERTAKER Jack Levin	ADDRESS

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10852 — 18 — D10852

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 Parkwood Av. St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice Pfeffer

(Residence in Baltimore: No. 1823 Wachbrodt Av St.; 30 yrs. ..... mos. ..... ds.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Separated 4 yrs.

6-DATE OF BIRTH: March 13th (Month) (Day) 1880 (Year)

7-AGE: 37 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O & D

9-BIRTHPLACE (State or country): Balto. Co. Md

PARENTS

10-NAME OF FATHER: Geo. H. Pfeffer

11-BIRTHPLACE OF FATHER (State or country): Gettysburg Pa.

12-MAIDEN NAME OF MOTHER: Margt A. Sugard

13-BIRTHPLACE OF MOTHER (State or country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beula D Pfeffer

(Address) 2830 Parkwood Av

15-

Filed ....., 191 ..... REGISTRAR

DEC 14 1917 AGNES R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 13th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1917 to, Dec 13th 1917, that I saw h[illegible] alive on Dec 13th 1917, and that death occurred, on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas.
Followed by Pneumonia
& Dropsy

Ant. (Duration) yrs mos. 20 ds.

Contributory (SECONDARY): Dropsy & Pneumonia of Lung

(Duration) yrs mos. 3 ds.

(Signed), E. A. Smith M. D.

Dec. 13th 1917. [Address] 1205 N. North Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Southern Cemetery — DATE OF BURIAL: Dec 17, 1917

20-UNDERTAKER: Joseph Lefler — ADDRESS: 1600 N North Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10853

CERTIFICATE OF DEATH.

64 D10853

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2128 Calloway St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edelmira P Wood

(Residence in Baltimore: No. 2128 Calloway St.; Life yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept. (Month) 19 (Day), 1834 (Year)

7-AGE, 83 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maty

PARENTS.

10-NAME OF FATHER, James Doran

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Helen L. Read

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Wood

(Address) 2128 Calloway ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 12 1917, that I saw h-e alive on Dec 11 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

a. Cerebral Hemorrhage

..... (Duration) yrs. 6 hours mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis - Kidneys

..... (Duration) 4 yrs. mos. ds.

(Signed) Jno. C. O'Clarke M. D.

Dec 14, 1917. (Address) 120 N. Wash. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Return Cemetery

DATE OF BURIAL, Dec. 15, 1917

20-UNDERTAKER P. Diamond & Son

ADDRESS Walbrook

D. Jeffries 1201 Madison ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10851

D10851

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3220 Elgin ave St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida S. Mason

(Residence in Baltimore: No. 3220 Elgin ave St.: 22 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 8, 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. 3 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Pa

PARENTS.

10-NAME OF FATHER, James A Stevenson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Amanda Detwiller

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Mason

(Address) 3220 Elgin ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1917, to Dec. 12 1917, that I saw her alive on Dec. 12 1917, and that death occurred, on the date stated above, at 12 o'clock m.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning (Uraemia)

Sudden onset

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Arteriosclerosis Aortic Insufficiency several years

(Duration) yrs. mos. ds.

(Signed) E. C. Todd M. D.

Dec. 13, 1917. (Address) 3101 Clifton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Dec 14, 1917

20-UNDERTAKER W. P. Redmond & Sons — ADDRESS Norfolk

DEC 13 1917

Dr. Todd 3101 Clifton ave

Ida Pree.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10855

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

189 D10855

REGISTERED NO. C

CITY OF BALTIMORE (No. 603 n Dallas St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Pree

(Residence in Baltimore: No. 603 n Dallas St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col	Boy

6-DATE OF BIRTH, Oct. 11, 1913
(Month) (Day) (Year)

7-AGE. yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): Bd.

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Arthur Pree

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Carrie Gretzman

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Gretzman

(Address) 603 N Dallas

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1913
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Lamotte M. D.
(Coroner.)

Dec 14, 1913. (Address) 4 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 14, 1913

20-UNDERTAKER Harry A Vodery ADDRESS 1725 Orleans

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10856

CERTIFICATE OF DEATH.

92 D10856

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4125 Potter Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Kaiserski

(Residence in Baltimore: No. 4125 Potter Ave. St.; 42 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 23 (Month) (Day), 1855 (Year)

7-AGE, 62 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Frank Kaiserski

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Mary.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Kaiserski

(Address) 4125 Potter Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 191 7, to Dec 11th 191 7, that I saw him alive on Dec 11th 191 7, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Coma

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) W. O. Russell M. D.

Dec 12, 191? (Address) Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard

DEC 14 1917

Spec.—8-24-14—M. & T.—2000 Bks.

Aaron Grossman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10857

D10857

CERTIFICATE OF DEATH.

61

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aron Grossman

(Residence in Baltimore: No. 1121 E. Fayette St.; 9 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October, 29, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Schulman, Draftsman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dora Schwartzman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Sears

(Address) 1411 E. Baltimore

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Dec 14 1917, that I saw him alive on Dec 14 1917, and that death occurred, on the date stated above, at 12.0 Clock m.

The CAUSE OF DEATH* was as follows:

Epistaxis Cerebro Spinal Meningitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) I. Jacobson M. D.

Dec 14, 1917 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1121 E. Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 12/14, 1917.

20-UNDERTAKER Jack Sears

ADDRESS 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10858 ✓ D10858

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. II2 Rochester Place. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip F. French.

(Residence in Baltimore: No. II2 Rochester Place. St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Widower

6-DATE OF BIRTH, October (Month) I4 (Day) 1837 (Year)

7-AGE, 80 yrs. I mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Henry French.

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Hannah Croy

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Joseph H. Schmidt

(Address)..... 112 Rochester Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) I3, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 20 1917, to December I3 1917, that I saw him alive on December I2 1917, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....Broncho-pneumonia.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

12-13-....., 191.7. (Address) 3139 E. Baltimore.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Trenton New Jersey

DATE OF BURIAL. Dec 17, 1917.

20-UNDERTAKER W M Cook

ADDRESS 502 E 20th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10859

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N Calvert ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathanael E. Sanford.

(Residence in Baltimore: No. 434 N Calvert st- St.; 67 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hotel Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Massachusetts

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Mass-

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sanford E. Sanford

(Address) Baltimore Mass.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8th 1917, to Dec 13 1917, that I saw h m alive on Dec - 13 1917, and that death occurred, on the date stated above, at 5 - m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

(Signed) N. K. Foreman M. D.

Dec 13, 1917. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, West Meade Mass. DATE OF BURIAL, Dec 14 1917.

20-UNDERTAKER W M Cook ADDRESS 502 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Fanny L. Dinges

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10860

CERTIFICATE OF DEATH.

D10860

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 243 Mc Curley ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Louisa Dinges

(Residence in Baltimore: No. 243 Mc Curley St.; 10 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 8 (Month) 2 (Day) 1870 (Year)

7-AGE, 27 yrs. 4 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank H Broders

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary E Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Dinges

(Address) 243 Mc Curley st.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 11 1917, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvic Organs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 14, 1917 (Address) [illegible] E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. mos. ds. In the State .... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, [illegible] 14, 1917

20-UNDERTAKER E. W. Dill. ADDRESS 309 Fredk ave

DEC 1 - 1917 REGIS. B. KRAUTER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10861

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10861

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 602 Waltemeyers Court St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Worley

(Residence in Baltimore: No. 602 Waltemeyer Court St.; 62 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)
Female	White	Widow

6-DATE OF BIRTH ..... (Month) ..... (Day), 1843 (Year)

7-AGE 74 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 60

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Jacobs

(Address) 602 Waltemeyer Ct

15-

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17, 1917, to, Dec 17 1917, that I saw h[er] alive on Dec 17 1917, and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

6 months

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY): Senility 1 year

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Edw. C. Bulet M. D.

Dec 18, 1917 [Address] 1529 N Fulton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Dec 15, 1917

20-UNDERTAKER: H. Fahey & Son — ADDRESS: 606 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1180 D10862

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1515 Race St. ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Euphemia Wagner

(Residence in Baltimore: No. 1515 Race St. St.; ....yrs. ....mos. 9ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 1, (Month) (Day) 1862 (Year)

7-AGE, 55 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William Taylor

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Euphemia Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Wagner

(Address) 1515 Race St.

15-

Filed....., 191.....

Registrar.

DEC 14 1917 ROBERT B. KRAUSE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1917, to Dec 12 1917, that I saw h.r alive on Dec 11 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) ....yrs. ....mos. 1 ds.

(Signed) R. B. Krause M. D.

Dec 11, 1917 (Address) 1515 Race St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Dec 14, 191...

20-UNDERTAKER J. Wm. L. Evans Son

ADDRESS 1718 Eutaw St.

Spec.—8-24-14—M. & T.—2000 Blks.

D10863 HEALTH DEPARTMENT—CITY OF BALTIMORE D10863

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Eulaw St., 11 WARD)

2-FULL NAME James A Thurber

(Residence in Baltimore: No. 722 Eulaw St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. Seven, 1 (Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country), Balto. 722 Eulaw St.

PARENTS.

10-NAME OF FATHER, James Thurber

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice Pettigrew

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Pettigrew

(Address) 722 Eulaw St.

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Birth 191..., to Dec. 13th 1917, that I saw h— alive on Dec. 13th 1917, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A. Lee Ellis M. D.

12/14, 191.. (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Elkridge Md. DATE OF BURIAL, Dec. 15 191.

20-UNDERTAKER John A. Bishop ADDRESS 1107 Druid

Spec.—8-24-14—M. & T.—2000 Bks.

D10861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10861

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 709 Druid Hill Ave ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Paul

(Residence in Baltimore: No. 709 Druid Hill Ave St.; Life yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

873

70

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... (Month) September (Day) 13 (Year) 1847

7-AGE, 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frederick Paul

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ann Kane

13-BIRTHPLACE OF MOTHER (State or Country), Ann Kane

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anita Paul

(Address) 1709 Druid Hill Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917, to Dec 12 1917, that I saw him alive on Dec 12 1917, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Chas. V. Fitzpatrick M. D.

Dec 13, 1917. (Address) 1118 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 14, 1917
20-UNDERTAKER John A. Bishop	ADDRESS 110 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D10865 HEALTH DEPARTMENT—CITY OF BALTIMORE D10865

CERTIFICATE OF DEATH.

REGISTERED NO. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2012 Wilhelm ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Miller

(Residence in Baltimore: No. 2012 Wilhelm St. St.; ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 11 (Day), 1917 (Year)

7-AGE, — yrs. — mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Miller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Hauk

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Miller

(Address) 2012 Wilhelm St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 13 1917, that I saw him alive on Dec 13 1917, and that death occurred, on the date stated above, at 9 4 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. A. Preis M. D.

Dec 13, 1917. (Address) 108 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Dec 14th, 1917
20-UNDERTAKER	**ADDRESS**
Knell & Son	1729 W Pratt st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10866

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1223 N Dallas St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edna Henry

(Residence in Baltimore: No. 1223 N Dallas St. 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem'l	Col	Sgle

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Houses
(b) General nature of industry, business, or establishment in which employed (or employer): Rest 107

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Theodore Henry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Henry

(Address) 1223 N Dallas

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Incipient Appendicitis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 11, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Dec 14th 1917

20-UNDERTAKER Chas. G. Bailey — ADDRESS 1417 Jefferson St

D10867

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10867

1720

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1428 Cerleans st St. 5 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Sutton

(Residence in Baltimore: No. 1428 Cerleans st St. 54 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Unk. (Month) (Day), 1863 (Year)

7 AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Thos Sutton

11 BIRTHPLACE OF FATHER (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Johnson

(Address) 1428 Cerleans St

15

Filed , 191 REGISTRAR

DEC 14 1917 ROBERT E. LAZENBY REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 .1917. to. Dec. 13 1917. that I saw h alive on Dec. 13th 1917. and that death occurred, on the date stated above, at 12.30 P m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY): Exhaustion

(Duration) yrs. mos. 5 ds.

(Signed) Dr Ellis M. D.

Dec 14, 1917. (Address) 1510 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: Dec 15th 1917

20 UNDERTAKER: Chas G. Bailey

ADDRESS: 1711 Jefferson st.

Spec.—8-24-14—M. & T.—2000 Bks.

D10868

Harry P. Bilson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10868

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H P Bilson

(Residence in Baltimore: No. 113 Oakley Avenue St.; 40 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 7 (Day), 1857 (Year)

7-AGE, 60 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer): O&B

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, William Bilson

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura V. Bilson

(Address) 113 Oakley Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 15th 1917, to December 14th 1917, that I saw h[illegible] alive on December 15th 1917, and that death occurred, on the date stated above, at 11-55 am.

The CAUSE OF DEATH* was as follows:

Anaemia

.....

.....

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Prostatic Abscess

..... (Duration) ....yrs. 1 mos. 3 ds.

(Signed) H. P. Bilson Jr. M. D.

....., 191... (Address) Franklin Square Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 113 Oakley Avenue

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec. 17..., 1917

20-UNDERTAKER John O'Mitchell — ADDRESS 1201 W Baltimore St.

D10869

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D10869

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 727 S. Bond St.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katrina Yzaurska

(Residence in Baltimore: No. 727 S Bond St.: 31 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOW, WIDOWER OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Dec 2, 1851 (Month) (Day) (Year)

7-AGE: 66 yrs. 10 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): Not Known

14-I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Zgurski

(Address) 1922 Bank

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 12, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1917, to Dec 12 1917.

that I saw h[illegible] alive on Dec 9th, 1917.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. 1 mos. ds

Contributory (SECONDARY) Old age & weakness incident thereto

(Duration) yrs. mos. ds.

(Signed) R. J. Hardy M. D.

Dec 14, 1917. (Address) 1902 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 15, 1917

20-UNDERTAKER: William Friedrich — ADDRESS: 618 Eastern Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

D10870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D10870

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 North Curley ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Luebeck

(Residence in Baltimore: No. 625 North Curley St.; 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan (Month) 14 (Day), 1887 (Year)

7-AGE, 30 yrs. 10 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, John Jedlicka

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Anna Krupicka

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice Luebeck

(Address) 2424 E. Monument St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 11 1917, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jacob Fisher M. D.

Dec 17, 1917. (Address) 1823 N. Wash St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec. 15, 1917

20-UNDERTAKER H. Sauder Sons — ADDRESS 1110 Pat St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1449

Spec.—8-24-14—M. & T.—2000 Bks.

D10871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10871

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonetta Mellin

(Residence in Baltimore: No. ~~Cor. Preston & Bond Sts.~~ from N. W. Cor Chase & Eden sts St.; 32 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 1 (Month) (Day) (Year)

7-AGE, About 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) 667

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph Mellin

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Theresa Pagel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. L. N. Mellin

(Address) No 529 N. Bond St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC. (Month) 13, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from DEC. 12 191 7, to DEC. 13 191 7, that I saw h Ee alive on DEC. 13 191 7, and that death occurred, on the date stated above, at 2.25 A m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Edward H. Smith M. D.

Dec. 13, 191... (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 1 ds. In the State ....yrs. mos. ds.

Where was disease contracted, if not at place of death? N. W. Cor Chase & Eden sts

Former or usual residence N. W. Cor Eutaw & Preston sts

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, Dec. 15, 191 7

20-UNDERTAKER Henry Hoeck Son ADDRESS 231 E Eager St

D10872

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10872

64

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 E. Monument ST: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Baker.

(Residence in Baltimore: No. 1818 E. Monument St.)

St.: (all her life) (49 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6-DATE OF BIRTH: May (Month) 10 (Day), 1868 (Year)

7-AGE: 49 yrs. 6 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Geo W. Genft

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Mary Bon

13-BIRTHPLACE OF MOTHER (State or country): England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Martha Baker

(Address) 1818 E. Monument St.

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December (Month) 13th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1917, to Dec 13 1917.

that I saw h- alive on Dec. 13, 1917.

and that death occurred, on the date stated above, at 7P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy or Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Arteriosclerosis & Hypertension.

(Duration) 3 yrs. — mos. — ds.

(Signed) David D. Market, M. D.

Dec. 14, 1917 (Address) 3218 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Jewish Cath Cemetery — DATE OF BURIAL: Dec. 17 1917

20-UNDERTAKER: Henry Hooch & Son — ADDRESS: 1301 E. Eager St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10873

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 W. Pratt ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank S Delehay Jr.

(Residence in Baltimore: No. 1927 W. Pratt St.; 31 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) M

6-DATE OF BIRTH, Aug 13th, 1886 (Month) (Day) (Year)

7-AGE, 31 yrs. 4 mos. 0 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank S Delehay Sr

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank S Delehay Sr

(Address) 1210 Hollins St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 11 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Acute

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis & Heart trouble

(Duration) yrs. mos. ds.

(Signed) J. E. Young M. D.

12-12-17, 191.7 (Address) 904 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Dec 15, 191.7

20-UNDERTAKER John J. Young & Son

ADDRESS 904 N. Charles St

Spec.—8-24-14—M. & T.—2000 Blks.

D10874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 ✓ D10874

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S Curley St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Humbleman

(Residence in Baltimore: No. 125 S Curley St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Single

6-DATE OF BIRTH, ... June (Month) 22 (Day), 1901 (Year)

7-AGE, 16 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Humbleman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Carrie Haupt

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Humbleman

(Address) 125 S Curley

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 191 7, to Dec 12 191 7, that I saw ~~him~~ her alive on Dec 12 191 7, and that death occurred, on the date stated above, at 11 20 P m.

The CAUSE OF DEATH* was as follows:

(1 Immediate) Endocarditis

.....

..... (Duration)....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Organic Conditions

..... (Duration)....yrs.....mos.....ds.

(Signed) P C Slade M. D.

12/13/17 191.. (Address) 143 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 15. 191 7

20-UNDERTAKER Wendell Dysard — ADDRESS 872 N

1917 Jan 23 1-15

Spec.—8-24-14—M. & T.—2000 Bks.

D10875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10875

CERTIFICATE OF DEATH.

X 40

1-PLACE OF DEATH Howard A Kelly Hospital Inc

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Mc Goff

(Residence in Baltimore: No. 1418 Eutaw Place St.; ....yrs.. ....mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	widow

6-DATE OF BIRTH, ...May.... (Month), ... (Day), 1875. (Year)

7-AGE.	If LESS than 1 day,
42 yrs. .... mos. .... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Kentucky

PARENTS.

10-NAME OF FATHER, William Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Rebecah Burgess

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Mitchell

(Address) Winchester Ky.

15-

Filed....., 191.....

.....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2 1917, to Dec 14 1917, that I saw h[illegible] alive on Dec 13 1917, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma on anterior surface of right thigh

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Sarcoma of liver

(Duration) ....yrs. 1 mos. 14 ds.

(Signed) Nell M. Ward M. D.

Dec 14, 1917. (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State ....yrs. ....mos. 12 ds.

Where was disease contracted, if not at place of death? Winchester. Ky.

Former or usual residence Winchester, Ky.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Winchester Clark Co. Ky	Dec. 14, 1917.
20-UNDERTAKER Chas. G. Black	ADDRESS 742 N. North ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10876

CERTIFICATE OF DEATH.

D10876

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1468 Woodall St.; 24 WARD)

2-FULL NAME Caroline Pipkin

(Residence in Baltimore: No. 1468 Woodall St.; ... yrs., ... mos. ... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October (Month) 17 (Day), 1853 (Year)

7-AGE, 64 yrs. 2 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, (2) Shanki

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mat. L. G. Burnett

(Address) 426 E. Clement St

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1917, to 14 Dec 1917, that I saw h[er] alive on 14 Dec 1917. and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ... yrs. ... mos. 2 1 ds.

CONTRIBUTORY (Secondary) Cholelithiasis. Jaundice

(Duration) ... yrs. 2 mos. ... ds.

(Signed) James Cowan M. D.

14 Dec, 1917 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, Dec 16, 1917

20-UNDERTAKER E. J. Canning — ADDRESS 1938 E. Lanvale St

5

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10877

D10877

CERTIFICATE OF DEATH.

REGISTERED No. C 71

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 627 E Clement (St.) 24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur L. Lowman

(Residence in Baltimore: No. 627 E Clement St (St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 24, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. 14 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Olie Lowman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Perkins

13-BIRTHPLACE OF MOTHER (State or Country), A A Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olie Lowman

(Address) 627 E Clement St

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 / 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/12 1917, to 12/14 1917, that I saw him alive on 12/14 1917, and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) 36 hours

CONTRIBUTORY (Secondary) Duration

Pneumonia (Duration) yrs. mos. ds.

I[Signed] L L Lurlington M. D.

12/17, 191 7 (Address) 402 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL. Dec 17, 191 7

20-UNDERTAKER Cumming & McCarthy

ADDRESS

5

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10873

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Bolton ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia L. Hamilton

(Residence in Baltimore: No. 1508 Bolton St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	widowed

6-DATE OF BIRTH, don't know ....., 1 .....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
70? yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Edw Lowndes

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Mary Guerard.

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H. Lowndes

(Address) 1508 Bolton St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13 1, 191 7
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1 191 7, to Dec 13 1 191 7,
that I saw h[er] alive on Dec 12 1 191 7,
and that death occurred, on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) C. Lowndes M. D.

Dec 14, 191 7 (Address) 1327 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem

DATE OF BURIAL. Dec 15th, 191 7

20-UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Orchard Sts

S 15

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

D10879

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 Vincent Pur Asylum

CERTIFICATE OF DEATH.

91 D10879

1-PLACE OF DEATH 1401 Division

CITY OF BALTIMORE: (No.) ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Mahus

(Residence in Baltimore: No. 1401 Division St.; yrs. 10 mos. 4 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARYLAND REGISTER OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, February 8, 1917. (Month) (Day) (Year)

7-AGE, yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Harry Mahus

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country) Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Rousseau

(Address) 1219 Madison Ave.

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1917, to Dec 12, 1917, that I saw her alive on Dec 12 1917, and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Edward M. C. Parker M. D.

, 191... (Address) 1201 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 14 ds. In the State yrs. 10 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cumberland Md.

19-PLACE OF BURIAL OR REMOVAL. Ellerslie Md. DATE OF BURIAL. Dec. 13 191 7.

20-UNDERTAKER Marlow Funeral Co. ADDRESS 1216 Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

D10880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10880

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 N. Appleton St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Kraft Eccleston

(Residence in Baltimore: No. 723 N. appleton St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar 23, 1883 (Month) (Day) (Year)

7-AGE, 34 yrs. 8 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William A. Kraft

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Eleanor L. Mills

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry Burtee

(Address) 723 N. Appleton St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9- 1917, to Dec 13 1917, that I saw her alive on Dec 13 1917, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. Hollis Blumer M. D.

Dec 14, 1917. (Address) 2000 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER Bertram Goss — ADDRESS 1212 W. Lafayette Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10881

CERTIFICATE OF DEATH.

79

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 24 E. Madison St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy D. Smith

(Residence in Baltimore: No. 24 E. Madison St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm Holmes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Thompson

13-BIRTHPLACE OF MOTHER (State or Couutry), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry G. Smith

(Address) 24 E. Madison

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Cardiac dilation

(b) .....

(c) Old Age (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Pulmonary Edema

Short time (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley M. D.
(Coroner.)

Dec 14, 191 7 (Address) 1629 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St John's P.E. Cy (Towson) DATE OF BURIAL, Dec 16, 1917.

UNDERTAKER Stewart Mowell & Co ADDRESS 108 W Monument

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10882

CERTIFICATE OF DEATH.

D10882

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 S Carey ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys E. Seelye

(Residence in Baltimore: No. 1117 S Carey St.; 1 yrs., 7 mos. 25 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, April (Month) 19 (Day), 1916 (Year)

7-AGE, 1 yrs. 7 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George T. Seelye

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Loretta McArdle

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George T. Seelye

(Address) 1117 S. Carey St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Dec 14 1917, that I saw her alive on Dec 13 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 17 ds.

(Signed) E. V. Cumberland M. D.

12/14/17 191... (Address) 74 W Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 17..., 191.7.

20-UNDERTAKER J. A. B. Cook

ADDRESS 1023 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D10883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10883

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tony Hallesandro (Delesandro)

(Residence in Baltimore: No. 530 S. Fulton Ave St.; 17 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 23, 1873
(Month) (Day) (Year)

7-AGE, 44 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Frank Hallesandro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Elizabeth Bruno

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Kirk

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 7 1917, to Dec 13 1917, that I saw him alive on Dec. 13 1917, and that death occurred, on the date stated above, at 7 47 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of forehead,

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Brain abscess & meningitis

(Duration) yrs. mos. ds.

(Signed) W. E. Ward M. D.

Dec. 14., 191.7. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 530 S. Fulton Ave.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Dec. 15, 1917.

20-UNDERTAKER, Jos Block — ADDRESS 1003 W Baltimore St

Spec.—5-19-13—M. & T.—500 Bks.

D10881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 ✓ D10881

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Columbia Av ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard E Bell

(Residence in Baltimore: No. 1119 Columbia Av St.; Life yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	

6-DATE OF BIRTH, Dec 19 (Month) (Day), 1917 (Year)

7-AGE, — yrs. — mos. — ds. If LESS than 1 day, 12 hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), 1119 Columbia Av

PARENTS.

10-NAME OF FATHER, Earl L Bell.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Davis

13-BIRTHPLACE OF MOTHER (State or Country), Penna Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl L Bell

(Address) 1119 Columbia Ave

15-

Filed ....., 191....

Registrar.

DEC 11 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 191, to Dec 16 1917, that I saw h[im] alive on Dec 13 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

(a) Carbuncle of Foramen Cecum

(b) Toxemia

(c) .....

(Duration) 12 hrs

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard Hain M. D.

Dec 16, 191 (Address) 327 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 17, 191
20-UNDERTAKER	ADDRESS
Jos B Cook	1003 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10885

CERTIFICATE OF DEATH.

+37 D10885

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd Smith

(Residence in Baltimore: No. Mercy Hospital St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, ... Not Known ....., 1..... (Month) (Day) (Year)

7-AGE, 40 ? ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp

(Address) Ashton Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 7 ....., 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 4 1917, that I saw him alive on Dec 4 1917 and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation Typhosis

Not Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H. Smith M. D.

Dec 9, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Mt. Airy Md.

Former or usual residence Mt Airy Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

Commissioner Health.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10886

CERTIFICATE OF DEATH.

91 D10886

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 415 n Regester ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda M Bennett

(Residence in Baltimore: No. 415 n Regester St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Bel

6-DATE OF BIRTH, Oct 22, 17

(Month) (Day) (Year)

7-AGE, ... yrs. 1 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henri Bennett

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Eliz Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz Cooper

(Address) 415 n Regester

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 191...

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Per. Wm. E. Woodall

Spec.—8-24-14—M. & T.—2000 Bks.

D10887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D10887

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Portland ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Müller

(Residence in Baltimore: No. 720 Portland St.; 60 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 2 (Day), 1840 (Year)

7-AGE, 77 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House
(b) General nature of industry, business, or establishment in which employed (or employer). Wife

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Fuger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gothard

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Müller

(Address) 720 Portland St

15-

Filed....., 191.....

Registrar.

DEC 15 1917 ROGER B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 13 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1917, to Dec 13 1917, that I saw h[illegible] alive on Dec 9 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

3?

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. 3 mos. ....ds.

(Signed) J M Dreese M. D.

Dec 14, 191?. (Address) 621 Columbia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec 15, 191?

20-UNDERTAKER Geo Lemmert & Son ADDRESS 647 W Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

D10888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10888

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 W Broadway ST.; 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Brohmann

(Residence in Baltimore: No. 1303 W. Broadway St.; 27 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	married

6-DATE OF BIRTH. January 8th, 1867. (Month) (Day) (Year)

7-AGE. 50 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER. John Brohmann

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Brohm, M.D.

(Address) 2202 W. Northern.

15-

Filed....., 191.....

Registrar.

DEC 15 1917 REGISTRAR R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-1-1917, to 12-13-1917, that I saw h[illegible] alive on 12-12-1917, and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia (Double lobar)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cirrhosis, muscular

(Duration) ....yrs. 10 mos. ....ds.

(Signed) H. Brohm M. D.

12-13-1917 (Address) 2202 W. Northern.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Dec. 17th, 1917.
20-UNDERTAKER Charles F. Dill.	ADDRESS 3109 Frdk. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10889 ✓ 103 D10889

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 520 W Saratoga St.: 4 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dina Snowden

(Residence in Baltimore: No. 520 W Saratoga St.)

35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Texas

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaiah Snowden

(Address) Brooklyn Md. c to

15-

Filed DEC 15 1917, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) H. L. Driscoll M. D.
(Coroner)

Dec 12, 1917. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, DEC 14 1917

20-UNDERTAKER Sam'l H. Chase & Son — ADDRESS 1400 Mosher

Spec.—5-19-13—M. & T.—500 Bks.

D10890

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 ✓ D10890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 N Payson ST.: 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Stewart

(Residence in Baltimore: No. 110 N Payson St.: Life time (yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Unknown ..... (Month) (Day) (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Stewart.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary. Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M Marley

(Address) 110 N Payson St

15-

DEC 15 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 191 , to Dec 12 191 , that I saw h— alive on Dec 12 191 . and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(Duration) yrs. mos. 4 ds.

(Signed) Edw Greenbaum M. D.

Dec 14, 1917. (Address) 211 Cath

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, DEC 15 1917, 191

20-UNDERTAKER Geo A Gerber

ADDRESS Balto & Payson Sts

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10891 ✓ D10891

CERTIFICATE OF DEATH.

15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Guilford Ave ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kutzler

(Residence in Baltimore: No. 2410 Guilford Ave St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, 12 (Month) 14 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
.....yrs.....mos.....ds.	....hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, August J. Kutzler

11-BIRTHPLACE OF FATHER (State or Country), New York City

12-MAIDEN NAME OF MOTHER Fred Sophie Krueger

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August J. Kutzler

(Address) 2410 Guilford Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-14 1917, to 12-14 1917, that I saw him alive on 12-14 1917, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows: —

Congenital Debility

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Estelle Hunnig M. D.

12/14, 1917 (Address) 2000 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cemetery	....., 191...
20-UNDERTAKER	**ADDRESS**
Geo. A. Kerby	Baltimore

56

Spec.—8-24-14—M. & T.—2000 Bks.

Julia Joye.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10892 + 40 D10892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hosp REGISTERED NO. C

CITY OF BALTIMORE: (No. Caroline & Oliver ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Joye

(Residence in Baltimore: No. Fullerton Md St.; ..... yrs., ... mos. 14 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, Oct. 28, 1839. (Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Wm Elliott.

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Anna Brown.

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Joye

(Address) Belair Rd. Fullerton

15-

Filed....., 191.....

Registrar.

DEC 15 1917 GORDON H. KRAUNES

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver & Gall Bladder

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) yrs. mos. 2 ds.

(Signed) Henry Merkel M. D.

....., 191... (Address) [illegible] N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. 14 ds.

Where was disease contracted, if not at place of death? Dont Know.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Terra Alta Preston W Va. DATE OF BURIAL, Dec. 17, 1917.

20-UNDERTAKER Wm Cook ADDRESS 836 E Monu

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10893

CERTIFICATE OF DEATH.

79 D10893

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 Garrison Ave ST.; 30 WARD)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Susan Koontz

(Residence in Baltimore: No. 323 Garrison Ave St.; 30 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, 3 (Month) 5 (Day), 1843 (Year)

7-AGE, 74 yrs. 8 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, David Bloom

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Casanda Stein

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt E Koontz

(Address) 323 S Garrison Ave

15-

Filed ....., 191.....

Registrar.

DEC 15 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Dec 13 1917, that I saw her alive on Dec 12 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) 10 mos. 1 ds.

(Signed) Henry J Haber M. D.

Dec 14, 1917 (Address) 508 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER George E Schwab-Bro

ADDRESS 2101 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10894

CERTIFICATE OF DEATH.

86 ✓ D10894

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3753 Dorsey Lane St.; 20 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Stewart

(Residence in Baltimore: No. 3753 Dorsey Lane St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... Feby (Month) 5 (Day), 1917 (Year)

7-AGE, ...yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John E. Stewart

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Louise Wheeler

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Stewart

(Address) 3753 Dorsey Lane

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 14 1917, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Acute Mas o - Pharyngeal Infection

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Howard W Jones, M. D.

Dec 15, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 17, 191...

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 15 1917

1530

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10895

CERTIFICATE OF DEATH.

90 D10895

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 110 N. Vincent ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Riah Johnson

(Residence in Baltimore: No. 110 N. Vincent St.; 7yr, mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (~~Write~~ the word.) Single

6-DATE OF BIRTH, March (Month) ....., 1881. (Day) (Year)

7-AGE, 36 yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Johnson

(Address) 110 N. Vincent St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 13 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec. 13 1917, that I saw him alive on Dec 13, 1917, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) W. H. Monkland M. D.

Dec. 15, 1917. (Address) 303 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, At Zions — DATE OF BURIAL, Dec 15, 1917.

20-UNDERTAKER Brown & Buckland — ADDRESS 114 N. Schroeder St.

Spec.—8-24-14—M. & T.—2000 Bks.

D10896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D10896

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 N Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ransom Speaks

(Residence in Baltimore: No. 800 Pierce St.; 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown, ... (Day) 1 (Year)

7-AGE, ... 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Salesman

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Speaks

(Address) 800 Pierce St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 ..... 1917, to Dec 12 1917, that I saw h~~im~~er alive on Dec 12 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Mellenthin M. D.

Dec 14 1917. (Address) 1808 N. Pine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec. 15..., 1917.

20-UNDERTAKER Brown & Berlan

ADDRESS 1140 N. Schroeder St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

William Clagey.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10897

D10897

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Clagey

(Residence in Baltimore: No. 612 Wyath St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... October, 13, 1876.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Albert Clagey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lina Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Clagey

(Address) 1422 N. Leighton

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December 13th, Thursday, 1917...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5, 1917, to Dec 13, 1917, that I saw h alive on Dec 13 1917, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

..... (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Typhoid fever

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 612 Wyath St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 15, 191..

20-UNDERTAKER Wm J Ecker & Son ADDRESS Balt & Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10898

CERTIFICATE OF DEATH.

91 D10898

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Lewin

(Residence in Baltimore: No. 13 N Caroline St St.: 15 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8 1917 to Dec 14 1917, that I saw h[illegible] alive on Dec 14 1917, and that death occurred, on the date stated above, at 11.25 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

..... (Duration) yrs. 3 mos. ds.

(Signed) [signature] M. D.

Dec. 15 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 13 N Lewin St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 12/16, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Baltimore St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10899

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1715 N Dunbar ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J Richards

(Residence in Baltimore: No. 1715 N Dunbar St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ..Sept..28.., 1846.
(Month) (Day) (Year)

7-AGE, 71 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Apprentice

9-BIRTHPLACE, (State or Country), Balto Co.

PARENTS.

10-NAME OF FATHER, John Richards

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Emma Orland

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Richard

(Address) 1715 N Dunbar

15-

DEC 15 1917

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 15, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Dec 17, 1917
20-UNDERTAKER	ADDRESS
Wm Cook	502 E. North

Spec.—8-24-14—M. & T.—2000 Bks.

Elma Raun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10900

CERTIFICATE OF DEATH.

9 D10900

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hosp Hospt St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elma Rauns

(Residence in Baltimore: No. 846 St Peter St St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. ..... (Month) Jan (Day) ....., 1913. (Year)

7-AGE.	If LESS than 1 day,
4 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Home~~

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Raun

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lucy Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elma Raun

(Address) 846 St Peter St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1917, to Dec 15 1917, that I saw her alive on Dec 15 1917, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchos Pneumonia

..... (Duration) about yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Pharyngeal Diphtheria

..... (Duration) yrs. mos. 3 ds.

(Signed) B. B. Braunbeck M. D.

Dec 15, 1917. (Address) Lunie Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 19 ds. In the State yrs. Life mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 846 St Peter St.

19-PLACE OF BURIAL OR REMOVAL, Balt County

DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER Geo Lunsdale & Co

ADDRESS 627 N Eut St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10901

CERTIFICATE OF DEATH.

D10901

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1248 Mc Elderry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Milhiser

(Residence in Baltimore: No. 1248 Mc Elderry St.; 9 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH, Nov. 17 (Month) (Day), 1866 (Year)

7-AGE, 51 yrs. — mos. 28 ds.

If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stocks Bonds
(b) General nature of industry, business, or establishment in which employed (or employer): Schluss Bros

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Samuel Milhiser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ella Blum

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph F. Milhiser

(Address) 1651 Appleton St.

15-

Filed DEC 15 1917, 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/11 1917, to 12/14 1917, that I saw h[illegible] alive on 12/14 1917, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

1. Chronic Alcoholism

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) yrs. mos. 4 ds.

(Signed) G. L. Thornton M. D.

12/15, 1917 (Address) 233 Augusta

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Jahrens & Ed — ADDRESS 1611 Mad ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D10902

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Brookfield Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Lein

(Residence in Baltimore: No. 2529 Brookfield Ave St.; 5 Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, March 11, 1841.
(Month) (Day) (Year)

7-AGE, 76 yrs. 9 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Simon J Glock

11-BIRTHPLACE OF FATHER (State or Country), Bavaria

12-MAIDEN NAME OF MOTHER Barbara Rider

13-BIRTHPLACE OF MOTHER (State or Country), Bavaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. John Lein

(Address) 2529 Brookfield Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 12, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1900, to 12-13 1917, that I saw h-d alive on 12-12 1917, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Complication: Cardio-vascular disease

(Duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilation of heart

(Duration) yrs. 4 mos. ds.

(Signed) R. G. Garrett M. D.

12-12, 191... (Address) 1621 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew — DATE OF BURIAL, Dec. 16....., 1917.

20-UNDERTAKER J Ahrens & Co — ADDRESS 1611 Mad Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spcc.—8-24-14—M. & T.—2000 Bks.

D10903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 ✓ D10903

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Brune ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Lee

(Residence in Baltimore: No. 606 Brune St.; 44 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ... (Month) — (Day) — , 1873 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Quel Laborer

9-BIRTHPLACE, (State or Country) Fairfax C.H. Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Dudson

(Address) 606 Brune St

15-

DEC 15 1917

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec 12 1917, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

.....

1a From Lobar pneumonia

..... (Duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) — yrs. — mos. 10 ds.

(Signed) Edward G. Mackenzie M. D.

Dec 13, 191... (Address) 1339 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
National Cem	12/15, 1917
20-UNDERTAKER Samuel I Hamilton	ADDRESS 578 W Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10904

D10904

10 V

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Druid Hill Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Johnson

(Residence in Baltimore: No. 1908 Druid Hill Ave St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ... Unknown (Month) ....., 18[illegible] (Day) (Year)

7-AGE,	If LESS than 1 day,
..... 72 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Lexington Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Lucy Stewart

(Address)..... 1908 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 14 1917, that I saw him alive on Dec 12 1917, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

..... Acute Nephritis (a)

..... (b)

..... (c)

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Daugherty M. D.

....., 191... (Address) 1607 Pams Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	12/16/17
20-UNDERTAKER	ADDRESS
Samuel Hemsley	578 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10905

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W Johnson

(Residence in Baltimore; No. 328 W Hoffman St St.; 60 yrs., mos. ds.)

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 20, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Store

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jas Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Leighman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Hamilton

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 7 1917, to Dec 12 1917, that I saw h alive on Dec 12 1917, and that death occurred, on the date stated above, at 8:00 p m.

The CAUSE OF DEATH* was as follows:

Cancer of oesophagus

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Oesophageal obstruction

(Duration) yrs. 1 mos. ds.

(Signed) C H Bloomfield M. D.

Dec 13, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 328 W. Hoffman st

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 12/16, 1917

20-UNDERTAKER Samuel Kennedy

ADDRESS 578 W Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10906

CERTIFICATE OF DEATH.

150 D10906

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Framm

(Residence in Baltimore: No. 214 S. Eden Street St.; — yrs., — mos. 3 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sing.

6-DATE OF BIRTH, December 12, 1917 (Month) (Day) (Year)

7-AGE, — yrs. — mos. 3 ds.

If LESS than 1 day, — hrs. or — min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Md Maryland.

PARENTS.

10-NAME OF FATHER, Abel Framm

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Framm

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Framm

(Address) 214 S. Eden St

15-

Filed ....., 191.....

Registrar.

DEC 15 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 191.7 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 14 1917, that I saw h[illegible] alive on Dec 14 191[illegible] and that death occurred, on the date stated above, at 1 25 A.M.

The CAUSE OF DEATH* was as follows: Congenital Malformation Spina Bifida - death 2 hours after operation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec 14, 191.7 (Address) Johns Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1/25 ds. In the State — yrs. — mos. 3 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 214 S. Eden

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Dec. 15, 191.7

20-UNDERTAKER A. Lipman & Bro

ADDRESS 110 E Baltimore St

D10907

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10907

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 651 W. Lexington St.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Donahoo

(Residence in Baltimore: No. 651 W. Lexington St.: yrs. 4 mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April (Month) 18 (Day), 1890 (Year)

7-AGE: 27 — 27 yrs. 7 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: James Zanders

11-BIRTHPLACE OF FATHER (State or country): Carroll Co., Md

12-MAIDEN NAME OF MOTHER: Elizabeth Zingling

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John William Donahoo

(Address) 651 W. Lexington St

15-

Filed DEC 15 1917, 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 14th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13th 1917, to Dec 14th 1917, that I saw h.. alive on Dec 14th, 1917, and that death occurred, on the date stated above, at 2.30 P. m.
The CAUSE OF DEATH* was as follows:

Coma

(Duration) ... yrs. ... mos. 1 ds

Contributory (SECONDARY) Apoplexis Chronica

(Duration) one yrs. ... mos. ... ds.

(Signed) E. B. Ward M. D.

12/14/17, 191 (Address) Greene & Fayette Sts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Van Bibber Md

DATE OF BURIAL: Dec 15, 1917

20-UNDERTAKER: W. M. Routson

ADDRESS: 230 N. Greene

Spec.—8-24-14—M. & T.—2000 Bks.

John W. Oliver

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D1090S 92 ✓ D1090S

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Glenn alley 27 ST. WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wesley Oliver

(Residence in Baltimore: No. 807 Glenn alley St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown, (Day) ..... 1865 (Year)

7-AGE, 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(h) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, J. Oliver

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy Oliver

(Address) 807 Glenn alley

15-

Filed....., 191.....

Registrar.

DEC 16 1917

ROBERT B. KRAUTZ
Assistant Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Dec 14 1917, that I saw him alive on Dec 13 1917, and that death occurred, on the date stated above, at 7P, m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

.....

.....

..... (Duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Dis. of Heart

..... (Duration) yrs. 1 mos. 2 ds.

(Signed) O. W. Fisher M. D.

Dec 14, 1917. (Address) 714 S. Stricker

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 16, 1917

20-UNDERTAKER, Jno A Goudon — ADDRESS 142 W Hill St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Rosa Myrick

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10909

CERTIFICATE OF DEATH.

1917 D10909

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Myrick.

(Residence in Baltimore: No. 223 N Dallas St.; 8 yrs., mos. ds.)

N. B.—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col	Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1 ..... (Year)

7-AGE,	If LESS than 1 day,
34 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Rachel Miller

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Sullivan

(Address) 223 N Dallas St

15-

DEC 16 1917

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Fired shot

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 13 1917 (Address) 19 E. Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 223 N Dallas St

Usual residence 223 N Dallas St

~~Harley Beck Md~~

19-PLACE OF BURIAL, OR REMOVAL, Mdinerd a a Co. md | DATE OF BURIAL, Dec 16, 1917

20-UNDERTAKER Joseph a Farrell | ADDRESS 2319 Division St

Spec.—8-24-14—M. & T.—2000 Bks.

D10910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 D10910

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Belle Lobb

(Residence in Baltimore: No. 21 S. Bond St.; 3 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, April 7, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Abraham Lobb

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bessie Monson

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levin

(Address) 1411 E. Baltimore St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 2 1917, to Dec. 15 1917, that I saw her alive on December 15 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Moses Raskin M. D.

Dec. 15, 1917. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 21 S. Bond St.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Northwestern Ave. DATE OF BURIAL, Dec. 17, 191..

20-UNDERTAKER Jack Levin ADDRESS 1411 E Balto

(C.K.) RRK

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10911

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Kraft

(Residence in Baltimore: No. 808 W. Lombard St.: 53 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 12, 1864 (Month) (Day) (Year)

7-AGE, 53 yrs. — mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Harry Eusta

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Kraft

(Address) 808 W. Lombard St.

15-

Filed DEC 16 1917, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) — 14 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 12-3-1917, to 12-14-1917, that I saw h alive on 12-14-1917, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Clinical (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Ehlen M. D.

12-14-1917 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Mary W. Ehlen — ADDRESS 194 W. North ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10912

CERTIFICATE OF DEATH.

170 ✓ D10912

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Parrish St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Gant.

(Residence in Baltimore: No. 901 Parrish St.: 40 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR ~~OR RACE~~. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Not known, ... (Month) ..... (Day) 1 (Year)

7-AGE. 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hostler
(b) General nature of industry, business, or establishment in which employed (or employer): Horse Carriers 035

9-BIRTHPLACE, (State or Country), Edmondsburg Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Gant

(Address) 901 Parrish St

15-

Filed ....., 191.....

Registrar.

DEC 16 1917 ROBERT E. LEDERER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 9 1917, to Dec. 15 1917, that I saw h~~im~~ alive on Dec. 12 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) 4 yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 3 yrs. 1/2 mos. ds.

(Signed) Geo C Shannon M. D.

Dec 15, 1917. (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest Sentry

DATE OF BURIAL, ..., 191...

DEC 18 1917

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10913

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 401 E 23rd St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Blackwell

(Residence in Baltimore: No. 401 E 23rd St, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, August (Month) 1 (Day) ..... (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Blackwell

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) mother

(Address) 401 E. 23rd St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 7, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia, bronchial & lobular, following Laryngitis & tracheitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Dec 10, 1917, (Address) 1 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery

DATE OF BURIAL, Dec 12, 1917

20-UNDERTAKER James H. Dennis

ADDRESS 1203 Pennsylvania

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10917 D10917

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 L Walsh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milburn Langford Boswell

(Residence in Baltimore: No. 1802 L Walsh St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... (Month) 1 (Day) 25, (Year) 1910

7-AGE, ... 7 yrs. 9 mos. 18 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Milburn Henry Boswell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Dilver

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milburn Henry Boswell

(Address) 1802 L Walsh St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1917, to Dec 13 1917, that I saw h[illegible] alive on Dec 13 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) William Frey M. D.

Dec 13, 191 7 (Address) 1928 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DEC 17 1917

DATE OF BURIAL, ..., 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

DEC 16 1917 ROBERT R. KRAUTER

Mad 6272

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10915

CERTIFICATE OF DEATH.

167 D10915

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Johnson

(Residence in Baltimore: No. 10 W. Hughes st. St.; yrs. 7/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) Jan (Day) 1 (Year) .....

7-AGE, 6 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Cora Jones

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Jones

(Address) 10 W. Hughes

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 13 (Day) 191/ (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Burns general .....
..... Caused probably by matches, ...
..... accidental (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ..... Pneumonia .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... W. H. Wilkins ..... M. D.
(Coroner.)
Dec 15, 191 7 (Address) ..... 1659 Bank .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int Interments

DATE OF BURIAL, Dec 15, 1917.

20-UNDERTAKER Geo H Hoffot

ADDRESS 406 W Conway St

D10916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10916

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 840 Vine ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Hall

(Residence in Baltimore: No. 1024 Whatcoat St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... December (Month), 1 (Day), ... (Year)

7-AGE, 33 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Joseph. Hall

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nancy Moore

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nancy Hall
(Address) 1024 Whatcoat St

15-
Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13, 1917
(Month), (Day), (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Donnell (Coroner.) M. D.
Dec 13 1917. (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery
DATE OF BURIAL, Dec 17, 1917
20-UNDERTAKER Charles B Jones
ADDRESS 233 Pine St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 16 1917 ROBERT R. KRAUPER

D10917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10917

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 713 W Franklin St.; 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Harris

(Residence in Baltimore: No. 713 W Franklin St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 15 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, School boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Douglas Harris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Douglas Harris

(Address) 713 W. Franklin

15-

Filed ....., 191.... Registrar.

DEC 16 1917 ROBERT A. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Donnell M. D.
(Coroner.)

Dec 17, 191.7 (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Charles B Jones — ADDRESS 233 Pine St

D10918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10918

28

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1203 n wolf st. St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Riley Friedman

(Residence in Baltimore: No. 1203 n wolf st, St.; yrs., 8 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June, 1 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cabinet
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country), NC

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Della

(Address) 1203 n wolf st

15- DEC 16 1917 ADOLPH B. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Dec 17, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Dec 17..., 191...

20-UNDERTAKER Charles B. Jones

ADDRESS 235 n. Pine St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10919

CERTIFICATE OF DEATH.

92 D10919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Simpson

(Residence in Baltimore: No. 638 Vine St

St.; .....yrs.. mos. ds.)

abt 8

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	married

6-DATE OF BIRTH, August 23 (Month) (Day), 1883 (Year)

7-AGE, 34 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Stephen Simpson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Nichols

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 191 7, to Dec 14 191 7, that I saw h m alive on Dec 14 191 7, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Specific Disease)

(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis abscess

(Duration) ? yrs. ? mos.....ds.

(Signed) [illegible] M. D.

Dec. 14, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 12 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 638 Vine St

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL, Dec. 17, 1917.

20-UNDERTAKER Charles B. Jones ADDRESS 236 Park

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state AGE should be supplied CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10920

37 D10920

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 232 Bowers Ct. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Harrod

(Residence in Baltimore: No. 232 Bowers Ct.

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH,

..... (Month) ....., 1 ..... (Day) (Year)

7-AGE	If LESS than 1 day,
63 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

PARENTS.

9-BIRTHPLACE, (State or Country), Baltimore Maryland

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Crockett

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mokel

(Address) 232 Bowers Ct.

15-

DEC 16 1917 ERNEST S. KRAUTER

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 14, 1917

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhage of Lungs
Not tubercular of Pulmonary
Could find probably Arteriosclerosis
or specific nature (Duration), ... yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) James M. Fulton M. D.

(Coroner.)

Dec. 16 1917. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Dec. 18, 1917.
20-UNDERTAKER	**ADDRESS**
Charles B. Jones	2357 N. Pine

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10921 — 151 ✓ — D10921

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N. Rose ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pete Del Castello

(Residence in Baltimore: No. 923 N. Rose St.; — yrs., — mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) December (Day) 26, (Year) 1917

7-AGE, ... yrs. ..... mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Pete Del Castello

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Bettina Conte

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Liberatore

(Address) 923 N. Eutaw St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 16 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 191 7, to Dec 16 191 7, that I saw h— alive on Dec 16 191 7, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Tetanus Complication
Traumatic Otitis
..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cardiac Collapse
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wm. F. Peters M. D.

Dec 6 1917, (Address) 1 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cemetery	Dec 16, 191..
20-UNDERTAKER	**ADDRESS**
George J. Routh	1735 Harford Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10922

CERTIFICATE OF DEATH.

170 D10922

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Emma Keys.

(Residence in Baltimore: No. 1003 Appleton St. St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 22 (Day), 1854 (Year)

7-AGE, 63 yrs. 8 mos. 22 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Robt Skillman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Naomi Miller

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma J. Stevens

(Address) 1121 N. Bond St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 191 7, to Dec 14 191 7, that I saw her alive on Dec 14 191 7, and that death occurred, on the date stated above, at 9 10 p.m.

The CAUSE OF DEATH* was as follows:

.....(a) Uraemia.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) H. A. Bayorden M. D.

Dec. 14, 191 7. (Address) 1121 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 1 ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1003 Appleton St.

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec. 17. 1917

20-UNDERTAKER Henry Lutz — ADDRESS 1007 N. Bond

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

(Over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

7 D10923

CERTIFICATE OF DEATH.

28 ✓ D10923

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Belmont ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Lee Penn

(Residence in Baltimore: No. 3038 Belmont ave St.; 28 yrs., 4 mos. 3 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, August (Month) 11th (Day) 1889. (Year)

7-AGE, 28 yrs. 4 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book keeper
(b) General nature of industry, business, or establishment in which employed (or employer): R. J. Edelen Co.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Richard J Penn

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Susan D Young

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Carrie M Penn

(Address) 3038 Belmont ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 14 1917, that I saw h alive on Dec 13 1917, and that death occurred, on the date stated above, at 1030 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Tuberculosis of the epiglottis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis of larynx

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Gibson M. D.

Dec 15, 1917. (Address) 6 W. Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec 17th, 1917.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10924 ✓ D10924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615. E 35th St.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Kohlgruber

(Residence in Baltimore: No. 615. E. 35th St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug. 15th, 1850
(Month) (Day) (Year)

7-AGE, 67 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Buffaloo N. Y.

PARENTS.

10-NAME OF FATHER, Friedrich Kohlgruber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. K. F. Kohlgruber

(Address) 615 E. 35th St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec., 13, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11th 1917, to Dec. 13 1917, that I saw him alive on Dec. 13th 1917, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

.....

Cerebral Hemorrhage

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) William J. Pillsbury M. D.

Dec. 15, 1917. (Address) 2801 York Road.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec. 17th, 1917.

20-UNDERTAKER Philip Seward & Son ADDRESS 1193 E. Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10925 D10925

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E. Mt Vernon Place St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Campbell Small Franklin

(Residence in Baltimore: No. 24 E. Mt Vernon Place St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Widowed

6-DATE OF BIRTH October (Month) 22 (Day) 1843 (Year)

7-AGE, 74 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), York Pennsylvania

PARENTS.

10-NAME OF FATHER, Philip A. Small

11-BIRTHPLACE OF FATHER (State or Country). York Pennsylvania

12-MAIDEN NAME OF MOTHER Sarah Latimer

13-BIRTHPLACE OF MOTHER (State or Country), York Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. L. Hamblen

(Address) 14 Wall St New York

15-

Filed....., 191.....

Registrar.

DEC 16 1917 ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from oct 191?, to Dec. 15th 191?, that I saw h.r alive on Dec. 14th 191?, and that death occurred, on the date stated above, at 2:45 Am.

The CAUSE OF DEATH* was as follows:

Sarcoma of Right Kidney (Hypernephroma)

(Duration) 1 yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. DeBoyny M. D.

Dec. 15th, 191? (Address) Preston Baltimore Co. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
York Pa	12-17, 1917
20-UNDERTAKER Henry W. Jenkins & Co	ADDRESS Orchard Mc Culloh

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10926

CERTIFICATE OF DEATH.

67 D10926

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 Hilson St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs: Mary Ellen Willey

(Residence in Baltimore: No. 154 Wilson St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug 6, 1860
(Month) (Day) (Year)

7-AGE, 57 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Magazine writer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Rochester N. Y.

PARENTS.

10-NAME OF FATHER, Ethan Allen Hilby

11-BIRTHPLACE OF FATHER (State or Country), Hartlyme Conn

12-MAIDEN NAME OF MOTHER Demis Maria Hill

13-BIRTHPLACE OF MOTHER (State or Country), New York State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Mc Hilby

(Address) 154 Hilson St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1917, to Dec 14 1917, that I saw him alive on Dec 13 1917, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Wm S. Gratons M. D.

Dec 15, 1917. (Address) 2128 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec. 17, 1917
20-UNDERTAKER Geo J Smith	ADDRESS 1000 Fayette St

DEC 16 1917 ROBERT E. RAMSAY REGISTRAR OF VITAL STATISTICS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10927

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1327 Mosher St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Jane Kirkland

(Residence in Baltimore: No. 1327 Mosher St St. 38 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: November 12, 1851 (Month) (Day) (Year)

7 AGE: 66 yrs. 1 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): County Tyrone Ireland

PARENTS

10 NAME OF FATHER: James Watt

11 BIRTHPLACE OF FATHER (State or country): County Tyrone Ireland

12 MAIDEN NAME OF MOTHER: Mary Gillespie

13 BIRTHPLACE OF MOTHER (State or country): County Tyrone Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert S. Kirkland

(Address) 1327 Mosher St

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ~~July~~ December 14, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to Dec. 11, 1917, that I saw her alive on Dec 11, 1917, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Contributory (SECONDARY) Edema

(Duration) 2 yrs. 6 mos. 26 ds

Contributory (SECONDARY) Cystitis

(Duration) yrs. 2 mos. 5 ds.

(Signed) John Robinson M. D.

Dec. 14, 1917 (Address) 2010 W. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Dec 17, 1917

20 UNDERTAKER: Geo J Smith — ADDRESS: 1000 W Fayette st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

010928

HEALTH DEPARTMENT—CITY OF BALTIMORE

010928

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 207 W. Montgomery St. St.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William N. Brown. (C)

(Residence in Baltimore: No. 207 W. Montgomery St. St.: 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
37 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Calvert Co, Md.

PARENTS.

10-NAME OF FATHER, Thomas I. Brown. (C)

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co, Md.

12-MAIDEN NAME OF MOTHER Classie Gross. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James R. Gross. (C) uncle.

(Address) 207 W. Montgomery St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Pulmonary Tuberculosis.
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ste M. Earnhardt M. D.
Dec, 15th. 7 (Coroner)
....., 191... (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 15..., 1917
20-UNDERTAKER	ADDRESS
J. J. Broadbent	[illegible]

Spec.—8-24-14—M. & T.—2000 Blks.

D10929

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D10929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #28 S Durham ST.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll Richter

(Residence in Baltimore: No. 28 S Durham St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ...May.... (Month) ....7.... (Day) 1884 (Year)

7-AGE, 33 ....33.... yrs. ....7.... mos. ....7.... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....Paper hanger....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Richter

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Mc Kelden

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Richter

(Address) 28 S Durham

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...December.... (Month) ....14.... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191 7, to Dec 14 191 7, that I saw h alive on Dec 14 191 7, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

a ....Cerebral Hemorrhage....

b ....Brain Tumor....

c .....

(Duration) ....yrs. ....1.... mos. ....2.... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....E Walsh.... M. D.

Dec 17, 191.. (Address) ....145 Park....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, December 17 191 7

20-UNDERTAKER Kendall Apfelstadt — ADDRESS 378 Mon

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.-[illegible]-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10930

CERTIFICATE OF DEATH.

64 V D10930

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Hanover ST.; 23 WARD) REGISTERED No. C

2-FULL NAME Henry W. Bittorf

(Residence in Baltimore: No. 1141 Hanover St.; 37 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 19 (Day), 1861 (Year)

7-AGE, 55 yrs. 11 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Liquors

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Bittorf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Peters

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emily Bittorf

(Address) 1141 Hanover

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Dec 14 1917, that I saw him alive on Dec 14 1917, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Hammerbacher M. D.

Dec 16, 1917. (Address) 831 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, Dec. 17, 1917.

20-UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10934

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D10931

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 N. Smallwood ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Washington Hoopes

(Residence in Baltimore: No. 29 N. Smallwood St.; ..... yrs., ... mos. ..... ds.)

Life time

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 9 (Month) 7 (Day), 1847 (Year)

7-AGE, 70 yrs. 3 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). 03

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Franklin B. Hoopes

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Francis McCallister

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Caroline Hoopes

(Address) 29 N. Smallwood St.

15-

Filed ....., 191.....

Registrar.

DEC 16 1917 ROBERT A. GRAFTON

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 13 1917, that I saw him alive on Dec 13 1917, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) E. Keller Hemming M. D.

12/14, 1917. (Address) 700 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Wm. A. Gerber ADDRESS Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10932

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10932

64

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2501 N. Baltimore ST. 50 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Dintscher

(Residence in Baltimore: No. 2501 N. Baltimore St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: July 19 (Month) (Day), 1838 (Year)

7-AGE: 78 yrs. 4 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Peter Dintscher

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Gesina Ahrends

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hannah Dintscher

(Address) 2501 N Baltimore St

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 13 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1917, to Dec 13 1917, that I saw him alive on Dec 13th, 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 14 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Haff M. D.

Dec 14, 1917 (Address) 1643 N. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 17, 1917

20-UNDERTAKER: Geo D Gerity — ADDRESS: Baltimore City

Spec.—8-24-14—M. & T.—2000 Bks.

D10933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 ✓ D10933

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2133 Pennsylvania Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca V. Mantler

(Residence in Baltimore: No. 2133 Pennsylvania Ave St.; 30 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 16 (Day), 1848 (Year)

7-AGE, 69 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Geo P. Sauerwein

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Mary J. McSweeney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Mantler

(Address) 2133 Pennsylvania Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 13 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 13 1917, that I saw her alive on Dec 13 1917, and that death occurred, on the date stated above, at 8.20 p m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. ....mos. ....ds.

(Signed) M. Mantler M. D.

Dec 14, 1917. (Address) 108 N Butler Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	Dec 17 191 7
20-UNDERTAKER	ADDRESS
Geo A Gerber	Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10931

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D10931

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2435 Maryland Ave ST. 13 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Scowcroft Settle

(Residence in Baltimore: No. 2435 Maryland Ave ST. 9 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: December 29, 1839 (Month) (Day) (Year)

7-AGE: 77 yrs. 11 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired merchant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): England

PARENTS

10-NAME OF FATHER: Moses Settle

11-BIRTHPLACE OF FATHER (State or country): England

12-MAIDEN NAME OF MOTHER: Sarah Scowcroft

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Booth Settle

(Address) 107 E. Lexington St

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 15, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 -, 1917. to. Dec 15 1917.

that I saw h[illegible] alive on Dec 14 - .1917.

and that death occurred, on the date stated above, at 9½ a m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis

(Chronic)

(Duration) 2 0 yrs. mos. ds

Contributory (SECONDARY) Cardiac Asthenia -

(Duration) yrs. mos. 10 ds.

(Signed), Robert H. Mitchell - M. D.

Dec. 15, 1917 (Address) 2112 maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Dec 17, 1917

20-UNDERTAKER: Jos Iversen & Son

ADDRESS: 217 S. Para

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D10935

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Gilmor ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah M. Clement

(Residence in Baltimore: No. 530 N. Gilmor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec 23, 1833
(Month) (Day) (Year)

7-AGE, 83 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Mass.

PARENTS.

10-NAME OF FATHER, Jonathan Pecker

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Eliz. Dalton

13-BIRTHPLACE OF MOTHER (State or Country), Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Arthur Clement

(Address) 530 N. Gilmor

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1, 1917, to December 14, 1917, that I saw h... alive on December 13, 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Old age

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Weak heart

..... (Duration) yrs. mos. ds.

(Signed) Jno. Hood M. D.

Dec. 13, 1917. (Address) 630 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 17, 1917
20-UNDERTAKER	ADDRESS
W. J. Ecksenstein	Park & Pa

DEC 17 1917 REGISTER OF WILLS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10936

CERTIFICATE OF DEATH.

92 D10936

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Gettier

(Residence in Baltimore: No. 817 N Chester St.; ....yrs.,....mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan. (Month) 9th (Day), 1917 (Year).

7-AGE, ...yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Walter L Gettier

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Catherine Young

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter L Gettier

(Address) 817 N Chester

15-

Filed....., 191.....

Registrar.

DEC 14 1917 ROBERT E. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 14th (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 14 1917, that I saw him alive on Dec 14 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Coma Pneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(Duration) ....yrs. ....mos. 5 ds.

(Signed) W. J. R. [illegible] M. D.

Dec 15 191.., (Address) 1003 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	Dec 17, 191 7
20-UNDERTAKER Geo M Sing	ADDRESS 841 W Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10937

CERTIFICATE OF DEATH.

30 D10937

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1618 Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Bernice Weber

(Residence in Baltimore: No. 1618 Monroe Ward. St.; Life yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 19 (Day), 1915 (Year)

7-AGE, 2 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walker Blaine Weber

11-BIRTHPLACE OF FATHER (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER Alice H. Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walker Blaine Weber

(Address) 1618 Monroe St

15-

Filed....., 191.....

Registrar.

DEC 17 1917 ROBERT H. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec. 16 1917, that I saw her alive on Dec. 15 1917, and that death occurred, on the date stated above, at 3. a m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculosis

(Duration) 1 yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Infection from sores

Unknown Source (Duration) 2 yrs. mos. ds.

(Signed) George C. Heaman M. D.

Dec. 16, 191 7 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Dec. 6., 191..

20-UNDERTAKER Harry W. Eldridge ADDRESS 1974 W Baltimore

(Over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10938

CERTIFICATE OF DEATH.

92 D10938

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Edmondson Ave St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Kraft

(Residence in Baltimore: No. 913 Edmondson Ave St.; 65 yrs., — mos. 4 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 11 (Month), 1852 (Year)

7-AGE, 65 yrs. — mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fire Ins Co Agent
(b) General nature of industry, business, or establishment in which employed (or employer) 080

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles L Kraft

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline L. Herman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Kraft

(Address) 913 Edmondson Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1917, to Dec 15 1917, that I saw him alive on Dec 14 1917, and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Geo T. Kemp M. D.

....., 191... (Address) St James Apt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Dec 17, 191...

20-UNDERTAKER, Mrs A Rohde & Son

ADDRESS 730 Pa Ave

Joseph Carroll

D10939 HEALTH DEPARTMENT—CITY OF BALTIMORE D10939

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 701 Druid Hill Ave ST. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Carroll

(Residence in Baltimore: No. 701 Druid Hill Ave St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 14, 1907
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Carroll

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Edith Conish

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 701 Druid Hill Ave

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1918
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address)*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 16, 1918

20-UNDERTAKER Thomas Kinsella & Co

ADDRESS 1 W Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10940

CERTIFICATE OF DEATH.

38 D10940

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Gunning.

(Residence in Baltimore: No. 402 W Hoffman St.: 46 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Black	married

6-DATE OF BIRTH, unknown ....., 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) At Occupation

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Daniel Peck.

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Sarah Amos

13-BIRTHPLACE OF MOTHER (State or Country), Providence RI

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Gunning

(Address) 402 W Hoffman St.

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 14 1917, that I saw h er alive on Dec 14 1917, and that death occurred, on the date stated above, at 11:50 Pm.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gonococcal Salpingitis not known

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12/17, 1917. (Address) Waverly, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State life yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 402 W Hoffman

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	....., 191...
20-UNDERTAKER	ADDRESS
Samuel J Hunley	518 N Gilmor

DEC 17 1917 ROBERT H. KRAUTER

(Over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10911

CERTIFICATE OF DEATH.

119 D10911

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 N. Para ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Walter Ackles

(Residence in Baltimore: No. 653 N. Para St.: 4 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Black African

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, April (Month) ....., 1875 (Day) (Year)

7-AGE, 42 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... barber
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800 00

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, James H. Ackles

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jennie B. Burns

13-BIRTHPLACE OF MOTHER (State or Country). Fredk. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Violet Ackles

(Address) 653 N. Paca St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1917, to Dec 13 1917, that I saw h.. alive on ..12.. 1917, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Asthenia due to Myocardiosclerosis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 12 yrs. 6 mos. ds.

(Signed) F. Mitchell M. D.

Dec 13, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, 12/17, 1917

20-UNDERTAKER Saml T. Kennedy

ADDRESS 578 W. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10942

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 Covington ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Smith

(Residence in Baltimore: No. 1432 Covington St.; 20 yrs., — mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 12 (Month) 20 (Day), 1857 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), A. A. Co Md

PARENTS.

10-NAME OF FATHER, John Cochran

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, do not Know

13-BIRTHPLACE OF MOTHER (State or Country), Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James B. Smith

(Address) 1432 Covington st.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1916, to Dec 14 1917, that I saw her alive on Dec 12 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 15 1917. (Address) 135 E Montgomery St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Dec 17, 1917.

20-UNDERTAKER, John F Fahey & Sons

ADDRESS 1318 Lightst

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10943

CERTIFICATE OF DEATH.

120

D10943

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1167 Dexter St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M Heiligman

(Residence in Baltimore: No. 1167 Dexter St.

St.; Wife yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb (Month) 10 (Day), 1877 (Year)

7-AGE, 40 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Heiligman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katherine Batching

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Heiligman

(Address) 1167 Dexter Street

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 15 1917, that I saw her alive on Dec 15 1917, and that death occurred, on the date stated above, at 7 00 m.

The CAUSE OF DEATH* was as follows:

(a) Cerebral Hemorrhage

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 16, 191.7. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Dec 17, 191.7

20-UNDERTAKER McLean Cook

ADDRESS 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 17 1917 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

Millard Bone

D10911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10911

CERTIFICATE OF DEATH.

108

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Millard Bone

(Residence in Baltimore: No. 606 S. Lezeune St. St.; 1yr. 5 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mgd

6-DATE OF BIRTH, Don't Know (Month), (Day), 1906 (Year)

7-AGE, 11 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Bone

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Matilda ?

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rub

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 6 1917, to Feb 15 1917, that I saw h m alive on Feb 15 1917, and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

General Peritonitis following acute appendicitis with rupture (Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) 3

(Duration) yrs. mos. ds.

(Signed) Ernest G. Gover M. D.

Feb 16, 1917 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death? 606 S. Lezeune

Former or usual residence 606 S. Lezeune St.

19-PLACE OF BURIAL OR REMOVAL, Schwartz

DATE OF BURIAL, 2/19, 1917

20-UNDERTAKER William Cook

ADDRESS 502 E. Wall Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D10945

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N Mount ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H Rogers

(Residence in Baltimore: No. 1112 N Mount St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Don't Know, (Month) (Day) 1 (Year)

7-AGE 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Car Builder
(b) General nature of industry, business, or establishment in which employed (or employer). PRR

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Rogers

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Mercer

(Address) 1112 N Mount

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Dec. 15 1917, that I saw him alive on Dec 15 1917, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal hemorrhage

(Duration) 1 yrs. mos. ds.

(Signed) J. Thom Hudson M. D.

....., 191.7. (Address) 1061 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

DEC 17 1917 REGISTERED

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

D10946

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10946

REGISTERED No. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1307 Laurele St St.: 16 WARD)

2-FULL NAME Thelma May Barnsley

(Residence in Baltimore: No. 1307 Laurele St St.: 1 yrs. 11 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Baby

6-DATE OF BIRTH: Dec 24, 1915 (Month) (Day) (Year)

7-AGE: 1 yrs. 11 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Walter C Barnsley

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Emma May Hutchins

13-BIRTHPLACE OF MOTHER (State or country): Canada Ont.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Warwick E Barnsley

(Address) 538 E Baltimore St.

15-

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 14, 1917 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 7, 1917 to Dec 14 1917, that I saw her alive on Dec 14, 1917 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

1. B. Adenitis

(Duration) yrs. 3 mos. ds.

Contributory (SECONDARY) Exhaustion (Cachexia)

Acute Pneumonia (Duration) yrs. mos. ds.

(Signed), M. D.

....., 191 (Address) J H Houck Jr 1924 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Westernbcemetery

DATE OF BURIAL: Dec 17, 1917

20-UNDERTAKER: W M Routson

ADDRESS: 230 Greene

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10917

CERTIFICATE OF DEATH.

92 D10917

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 W Saratoga St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Atwood

(Residence in Baltimore: No. 624 Saratoga St.; 48 yrs., 11 mos. 24 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 20, 1868 (Month) (Day) (Year)

7-AGE, 48 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....housework.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Thomas Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aaron Ringgold

(Address) 624 W. Saratoga St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 14 1917, that I saw h[er] alive on Dec 14 1917, and that death occurred, on the date stated above, at 1.30p m.

The CAUSE OF DEATH* was as follows:

Intra Cerebral Hemorrhage

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) H. C. Haddaway M. D.

12/16, 191.7. (Address) 1717 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn | DATE OF BURIAL, Dec 17 191.7

20-UNDERTAKER W. M. Routson | ADDRESS 230 E. Greene

DEC 17 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D10918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D10918

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2930 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur G. Lappe

(Residence in Baltimore: No. 2930 E. Monument St.; 6/12 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) ..... (Day) 1908 (Year)

7-AGE, 9 yrs. 3 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at School
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George W. Lappe

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Lily M. Hynes

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Lappe

(Address) 2930 E. Monument

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 191.., to Dec 14 1917, that I saw h.. alive on 12/14 191.., and that death occurred, on the date stated above, at 7 00 a. m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

.....

.....

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Exanguinating Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Frank M. D.

12/15, 191.7. (Address) 729 N. Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 17, 191.7

20-UNDERTAKER H. Sander & Sons — ADDRESS 710 Park Ave

N. B.—Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10919

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 S. Robinson ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriett A. Greenville

(Residence in Baltimore: No. 1019 S. Robinson St.; 70 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb. (Month) 1 (Day), 1845 (Year)

7-AGE, 72 yrs. 11 mos. 13 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Thomas Davis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Hannah Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma J. Foxwell

(Address) 1019 S. Robinson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1917, to Dec 15th 1917, that I saw her alive on Dec 14th 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Jones M. D.

Dec 15th, 1917. (Address) 1513 E. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery | DATE OF BURIAL, Dec. 19... 191..

20-UNDERTAKER Zirkler & Zirkler | ADDRESS 1739 E. Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10950

CERTIFICATE OF DEATH.

REGISTERED NO. C 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Schaffer

(Residence in Baltimore: No. 1411 E. Biddle St.; 12 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 12 (Month) (Day) 1881 (Year)

7-AGE, 36 yrs. 11 mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watch maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Paul Schaffer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Auburn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilhelmina Schaeffer

(Address) 1411 E. Biddle

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13 Thursday 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 13 1917, that I saw h[illegible] alive on Dec 13 1917, and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Myocardial
Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

(Signed) [signature] M. D.

12/13, 1917. (Address) 1411 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 1411 E. Biddle St.

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, Dec 17, 1917.

20-UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

DEC 17 1917 ROBERT B. KRAUTER BURIAL PERMIT CLERK

D10951 HEALTH DEPARTMENT--CITY OF BALTIMORE 152 D10951

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1702 Westwood Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Mary Knight

(Residence in Baltimore: No. 1702 Westwood Ave St.: yrs. mos. 1½ ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 13, 1917 (Month) (Day) (Year)

7-AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 14 hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: George V Knight

11-BIRTHPLACE OF FATHER (State or country): Canada

12-MAIDEN NAME OF MOTHER: Amelia E Ehenoweth

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George V. Knight

(Address) 1702 Westwood Ave

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 16, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1917, to Dec 15 1917, that I saw h- alive on Dec 15, 1917, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred O Dewitt M. D.

Dec 15, 1917 (Address) 2516 Penna. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Olivet	Dec 17, 1917
20-UNDERTAKER	ADDRESS
Knight & Schmidt Bro	201 E Fayette Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10952

CERTIFICATE OF DEATH.

167

D10952

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula May Reeder

(Residence in Baltimore: No. 1601 Ramsay St.: 9 yrs., 8 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 24, 1908
(Month) (Day) (Year)

7-AGE, 9 yrs. 8 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Chas. Reeder

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Florence Edler

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Randle

(Address) 1601 Ramsay St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, thereon and from the evidence obtained by said Inquest, found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body 3d degree
from Clothes catching fire
Gas stove in her home

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs &
Epiglottis (Duration) ..... yrs. ..... mos. 1/2 ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Dec. 17, 1917. (Address) 710 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1601 Ramsey St

Former or usual residence 1601 Ramsey St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park.	Dec 18, 1917.
20-UNDERTAKER	ADDRESS
Geo. Eschmat & Bro	2101 Eutaw Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10953

CERTIFICATE OF DEATH.

79 D10953

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E Federal ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Buchal

(Residence in Baltimore: No. 1309 E Federal St.; 60 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May 20, 1857 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
60 yrs. 6 mos. 20 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman 639
(b) General nature of industry, business, or establishment in which employed (or employer): Grantwood Store

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Robert Buchal

11-BIRTHPLACE OF FATHER (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christina Buchal

(Address) 1309 E. Federal St.

15-

Filed....., 191.....

Registrar.

DEC 17 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1917, to Dec 15 1917, that I saw him alive on Dec 15 1917, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of heart

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John W. Anderson M. D.

Dec 16, 191 7. (Address) 1714 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
[redacted] Parnell County	Dec 18, 191 7.
20-UNDERTAKER	ADDRESS
Albert C Fuller	221 N Broadway

221 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

Daniel Hamrick

D10951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10951

+ 53

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Daniel Hamrich

(Residence in Baltimore: No. 4 mos 4 days (Johns Hopkins Hosp.) St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, September 22, 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Railroading
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Henry Hamrick

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Nancy Paynton

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 11 1917, to December 14 1917, that I saw h alive on December 14 1917, and that death occurred, on the date stated above, at 10 pm.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) C. F. Bloomfield M. D.

Dec. 15, 191.7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 4 mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hackers Valley W. Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pickens W Va	Dec. 16, 191.7

20-UNDERTAKER Elliott E. Fuller

ADDRESS 220 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10955

CERTIFICATE OF DEATH.

151

D10955

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Redfield

(Residence in Baltimore: No. 2121 Dukeland St ST.: 1 yrs., X mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) X

6-DATE OF BIRTH, Dec 13, 1917
(Month) (Day) (Year)

7-AGE, ...X... yrs. ...X... mos. ...2... ds.

If LESS than 1 day, ...hrs. or ....X....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....X....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Maryland Balto

PARENTS.

10-NAME OF FATHER, Charles B Redfield

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Margaret Wright

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas B Redfield

(Address) 2121 Dukeland St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1917, to Dec 15 1917, that I saw her alive on Dec 15 1917, and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ....X.... yrs. ....X.... mos. ....X.... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H Truitt M. D.

....., 191... (Address) 1 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. 2 ds.

Where was disease contracted, if not at place of death? 2121 Dukeland St

Former or usual residence 121 Dukeland St

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Dec 17, 1917

20-UNDERTAKER John B Hume

ADDRESS 1328 22 Caroline St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D10956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10956

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 St Ann Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Schellenschlager

(Residence in Baltimore: No. 628 St Ann Ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maine

PARENTS.

10-NAME OF FATHER, Arund Leighton

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER Elgia A. Burk

13-BIRTHPLACE OF MOTHER (State or Country), Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Stella

(Address) 628 St Ann Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 14 1917, that I saw h alive on Dec 13 1917, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Senile

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Debility

Indefinite

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

, 191... (Address) 231 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Dec 17, 191..

20-UNDERTAKER Christian Miller

ADDRESS 2334 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10957

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 N. Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hezekiah Gray

(Residence in Baltimore: No. 246 Bruce St.; Unknown yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, Unknown (Month), 1 (Day), (Year)

7-AGE 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 540

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gray

(Address) 246 N. Bruce st.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 15 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-5-17 191..., to 12-15-17 191..., that I saw h[illegible] alive on " 191..., and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Reid M.D.

12-15-17, 191... (Address) 1524 N. Eden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec. 18..., 1917.

20-UNDERTAKER A. Jones

ADDRESS 207 S. Stricker st

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10958

D10958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 E Federal ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Virginia Krause

(Residence in Baltimore: No. 2306 E Federal St.: 30 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 10 (Month) (Day), 1871 1870 (Year)

7-AGE, 46 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Nurse for 10 3

9-BIRTHPLACE, (State or Country), Balto Co Md.

PARENTS.

10-NAME OF FATHER, Thos J. Montgomery

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary C. Coe

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L. Krause

(Address) 2306 E Federal

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1917, to Dec 14 1917, that I saw h[er] alive on Dec 14 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Hypertension Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. ds.

(Signed) Dwight E. Gilbert M. D.

Dec 15, 1917 (Address) 1114 E Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Vaughn Chapel Fork Md

DATE OF BURIAL, Dec 17, 1917

20-UNDERTAKER ARMSTRONG-DENNY CO.

ADDRESS 715 Light St

DEC 17 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D10959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97 D10959

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1154 W. Hamburg ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip J. Brunner

(Residence in Baltimore: No. 1154 W. Hamburg St.; 9 yrs., ... mos. ..... ds.)

N. B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug 3, 1911. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 4 mos. 11 ds.	.... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Philip J. Brunner

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Myrtle Montgomery

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs P. Brunner

(Address) 1154 W. Hamburg st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 14 1917, that I saw h.. alive on Dec 14 1917, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. Hyslop Bryan M. D.

Dec ..., 191.7 (Address) (22) Clarke

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Dec. 17., 191.7.
20-UNDERTAKER James Dugan & Son	ADDRESS 1000 S. Paca St

D10960

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D10960

REGISTERED NO. C.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 N. Dallas St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Clark

(Residence in Baltimore: No. 1800 N Dallas St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Male	White	Single

6-DATE OF BIRTH May 17th (Month) (Day), 1890 (Year)

7-AGE 27 yrs. 6 mos. 27 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Bar Tender
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER Owen A. Clark

11-BIRTHPLACE OF FATHER (State or country) Baltimore

12-MAIDEN NAME OF MOTHER Dillea Jennings

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Charles Clark.

(Address) 1800 N. Dallas st.

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9, 1917, to, Dec 1917, that I saw h~~im~~ alive on 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs 10 mos. ds.

Contributory (SECONDARY) .....

(Duration) yrs. mos. ds.

(Signed) John W Sandusson M. D.

Dec 16, 1917. [Address] 1713 Carrollton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Dec. 17, 1917

20-UNDERTAKER: George F. Routh — ADDRESS: 1735 Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10961

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Appel.

(Residence in Baltimore: No. St. Joseph's Hospital St.; yrs., mos. 6 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Don't know, 1 (Month) (Day) (Year)

7-AGE, 85 years. yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Henry Appel.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Arndt

(Address) Harford & Benrick ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 15 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 12/9/1917, to 12/15/1917, that I saw h[illegible] alive on 12/15/1917, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Arterio Sclerosis.

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) J. Edw. F. Ennis M. D.

12/15/, 1917. (Address) St. Jos. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Don't Know

Former or usual residence Hanover Md

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery

DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER George J. Rueth

ADDRESS 1735 Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D10962

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Goldberg

(Residence in Baltimore: No. 2017 McCulloughs St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Oct. (Month) 1st (Day), 1847 (Year)

7-AGE, 70 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nathan Goldberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bessie Appleman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Oliver Wallington M. D.

(Address) Union Protestant Infirmary

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 16 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 4th 1917, to Dec. 16 1917, that I saw h[im] alive on Dec. 16, 1917, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Auricular fibrillation ? ?

..... (Duration) ..... yrs. ..... mos. 15+ ds.

(Signed) G. H. Mickelethwaite M. D.

Dec 16, 1917. (Address) U. P. I.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State 36 yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 2017 McCulloughs St. Balto. Md

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Dec. 18, 1917.

20-UNDERTAKER J. Ahrens & Co. — ADDRESS 1611 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10963 D10963

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Hollins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Morton

(Residence in Baltimore: No. 1101 Hollins St. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write word.) Single

6-DATE OF BIRTH, Sept 22, 1917.. (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Morton

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Bridget Burns

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Morton

(Address) 1101 Hollins St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 16, 1917.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 16 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 6-50 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ....yrs. 1/2 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ....yrs. ....mos. 5 ds.

(Signed) E. V. Cadalaan M. D.

12/17/17, 191... (Address) 24 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Dec. 17, 1917..

20-UNDERTAKER [illegible]

ADDRESS [illegible] 1208 W. Fayette

DEC 17 1917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D10964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D10964

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Harlem Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Templeton

(Residence in Baltimore: No. 906 Harlem ave St.; 2 yrs., 6 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Sept 11, 1837
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
80 yrs. 3 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): (retired)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Templeton

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Maria Burns

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. B. Templeton

(Address) 906 Harlem Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

3 hours
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) 2 yrs. 6 mos. ds.

(Signed) N. E. Kemp M. D.

Dec 17, 1917. (Address) 1002 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec 18, 1917
20-UNDERTAKER	ADDRESS
Geo M Little	531 N Fremont Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D10965

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 128 Augusta Ave St.: 20 WARD)

Registered No. C 79

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Conrad J. Sinkel

(Residence in Baltimore: No. 128 augusta ave St.: 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: apl (Month) 6 (Day), 1858 (Year)

7 AGE: 59 yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Sinkel

(Address) 128 Augusta Ave

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 14 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1917, to Dec 14, 1917, that I saw h[illegible] alive on Dec 14, 1917, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R Gustav Lee M. D.

Dec 17, 1917 (Address) 1433 Woodland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: Dec. 18, 1917

20 UNDERTAKER: Charles W. Dill ADDRESS: 3109 Orchard Ave.

Spec.—5-19-13—M. & T.—500 Bks.

D10966

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D10966

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Wilhelm St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John August Uhl (Estl)

(Residence in Baltimore: No. 2015 Wilhelm St.; 40 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, March 6, 1862 (Month) (Day) (Year)

7-AGE, 55 yrs. 9 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Uhl

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Marquitta Sauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Uhl

(Address) 2015 Wilhelm St

15-

Filed....., 191.....

Registrar.

DEC 17 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11 1917, to Dec 14 1917, that I saw h— alive on Dec 13 1917, and that death occurred, on the date stated above, at 8.2 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Rt. Upper Lung.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) A. B. Wilson M. D.

12-16, 1917. (Address) 1735 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cem	Dec 18 1917
20-UNDERTAKER, Charles W. Dill.	ADDRESS 3409 Frederick Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10967

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D10967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Furman

(Residence in Baltimore: No. 710 Light Street St.; 55 yrs., 7 mos. 7 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Russia ..... November 15, ... 1862
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 1 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Ike Furman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ida Barr

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1917, to Dec 16 1917, that I saw h im alive on Dec 16 1917, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hypoplexy .....

..... (Duration) ... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

..... (Duration) ... yrs. ... mos. 2 ds.

(Signed) ..... M. D.

Dec 16, 1917. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 710 Light St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Harmony	....., 191...
20-UNDERTAKER	ADDRESS
J & L Lewis	1411 E Balto

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10968

CERTIFICATE OF DEATH.

92

D10968

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1708 E Chase ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Hyris

(Residence in Baltimore: No. 1708 E Chase St.: 55 yrs., mos. ds.)

N. B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Aug 19, 1847 (Month) (Day) (Year)

7-AGE, 70 yrs. 3 mos. 14 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not-known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. D. W. Harlin

(Address) 1708 E. Chase St.

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 14 1917, that I saw her alive on Dec 14 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Harner M. D.

Dec 14, 1917. (Address) 1201 N. Pat Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, Dec 17, 1917.

20-UNDERTAKER Robt. T. Turner

ADDRESS 1429 N. Broadway

D10969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead University Hospital 17 2

CITY OF BALTIMORE (No. Consolidation Coal Co ST. Westport WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donat (Karczewski

(Residence in Baltimore: No. 133 S Regester St

28 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia Poland

PARENTS.

10-NAME OF FATHER, Andrew Karczewski

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER Frances Rynn

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorotha Karczewski

(Address) 133 S Regester St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental asphyxia by Coal Gas (In Coal Chute)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Jones Jr M. D.
(Coroner)

Dec 17, 1917 (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Consolidation Coal Co at Westport

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Dec 17, 1917

20-UNDERTAKER Wm Fialkowski — ADDRESS 160 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10970 D10970

CERTIFICATE OF DEATH. 28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529. S. Bond ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jozefa Skalinska

(Residence in Baltimore: No. 529 S. Bond St.: 25 yrs.. mos. ds.)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Not Known (Month) (Day) 1880 (Year)

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Peter Szamsk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Pawlak

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jeofa Skalinska

(Address) 529 S. Bond St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 15 1917, that I saw h- alive on Dec 14 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) limit of yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. T. Rao M. D.

Dec. 17, 1917. (Address) 24 Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus

DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER William Fiaszowski

ADDRESS 618 Eastern Ave

D10971

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

D10971

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Carey ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Hurley

(Residence in Baltimore: No. 214 N. Carey St ST.; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH Oct. 31" (Month) (Day), 1853 (Year)

7-AGE 64 yrs. 1 mos. 14 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Conrad Hurley

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Sarah

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy M. Hurley

(Address) 214 N. Carey St

15-

Filed ..., 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1917, to, Dec 14 1917, that I saw h.im alive on Dec 14" 1917., and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Et.
Arterial Sclerosis

(Duration) 3 yrs. 2 mos. 4 ds.

Contributory (SECONDARY) Cardiac asthma and dropsy

(Duration) 1 yrs. 1 mos. 14 ds.

(Signed), Herbert A. Zepp M. D.

Dec 16" 1917. [Address] 2038 N. Howard

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 17, 1917

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette

DEC 17 1917

Rebecca Huffman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10972

D10972

CERTIFICATE OF DEATH.

REGISTERED No. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 13 n Charles ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Huffman.

(Residence in Baltimore: No. 13 n Charles 60 St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, ...78.... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Rief

(Address) 107 N. Charles st.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Belair Rd	Dec 17, 1917

20-UNDERTAKER May Levinson ADDRESS 1107 E Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10973

CERTIFICATE OF DEATH.

92 D10973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Stockton St.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Jones

(Residence in Baltimore: No. 718 N. Stockton St.; 25 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Mar - 4 - , 1871 (Month) (Day) (Year)

7-AGE, 46 yrs. 9 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Howard Co Md.

PARENTS.

10-NAME OF FATHER, Geo Jones

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md.

12-MAIDEN NAME OF MOTHER Annie Savoy

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Jas T Warfield (Son) (Address) 524 N. Patrick

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec - 14 - , 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 14 1917, that I saw h[illegible] alive on Dec 14 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

.....

Lobar Pneumonia

..... (Duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) F. L. Smith M. D.

Dec 14, 1917. (Address) 1313 W North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mont Auburn

DATE OF BURIAL, Dec 18, 1917.

20-UNDERTAKER John F Owens

ADDRESS 534 Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D10974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 E. Fort Ave St.; 24 WARD)

REGISTERED No. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David W. McCauley

(Residence in Baltimore: No. 422 E. Fort Ave St.; 41 yrs., 8 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March 20, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engine
(b) General nature of industry, business, or establishment in which employed (or employer): Hoister

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER, John McCauley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth M. Cauley

(Address) 422 E. Fort Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1917, to Dec 15 1917, that I saw him alive on Dec 15 1917, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

(Signed) J. A. O'Donnell M. D.

Dec 17, 1917. (Address) 102 E. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER Wm. F. Evans Son

ADDRESS 1420 Madison Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. V27

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 17 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D10975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10975

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Ramsey St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie E. Kellerman.

(Residence in Baltimore: No. 739 Ramsey St St.; 31 yrs., 4 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 9 (Day), 1886 (Year).

7-AGE, 31 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-
(b) General nature of industry, business, or establishment in which employed (or employer): -wife

9-BIRTHPLACE, (State or Country) Baltimore Maryland.

PARENTS.

10-NAME OF FATHER, Chas E. Merson

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Ella May Disney

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Kellerman

(Address) 721 Ramsey

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15 (Day), 1917 (Year).

17-I HEREBY CERTIFY, That I attended deceased from Dec 1- 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Subinvolution of Uterus

(Duration) ....yrs. 6 mos. ....ds.

(Signed) W. C. Fuchs M. D.

12/16, 191.7 (Address) 6 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec. 18, 1917

20-UNDERTAKER Jos B Cook — ADDRESS 1037 Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10976 — 150 — D10976

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 717 Sarah Ann St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Proctor

(Residence in Baltimore: No. 717 Sarah Ann St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female — 4-COLOR OR RACE, Colored — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. 23, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 wks ds. — If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Proctor

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Martha Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Proctor

(Address) 717 Sarah Ann

15-

Filed ....., 191.....
Registrar.

DEC 17 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Linscall M. D.
(Coroner.)

Dec 15, 191.. (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 17 1917

ROBERT R. KRAUTZ Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D10977 HEALTH DEPARTMENT—CITY OF BALTIMORE D10977

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 759 W Cross ST.: 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Snyder

(Residence in Baltimore: No. 759 W Cross St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH. ..... Mar (Month) 28 (Day), 1902 (Year)

7-AGE. 15 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)..... HW

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Frank Snyder

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER Sallie Hollinger

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Snyder

(Address) 759 W Cross St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 16 1917, that I saw h[illegible] alive on Dec 16 1917, and that death occurred, on the date stated above, at 11A m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis

(Duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) R. E. L. Campbell M. D.

Dec 16, 1917. (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER Pew & McCully.	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10978

CERTIFICATE OF DEATH.

D10978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N. Mount St.; 16th WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cassandra Wiley Mitchell

(Residence in Baltimore: No. 1008 N. Mount St.; 83 yrs., 11 mos. 17 ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: December 29, 1833 (Month) (Day) (Year)

7-AGE: 83 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: Walter Daniels

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Anne Litzinger

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar C. Mitchell

(Address) 2815 Evergreen Avenue

15-

Filed....., 191.....

Registrar.

DEC 17 1917 ROBERT T. BRAUTEN Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 16 1917, that I saw her alive on Dec 15 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Homer C. Todd M. D.

Dec. 16, 1917. (Address) 735 N. Linton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER: Fredk Lazarus Sons

ADDRESS: Fullerton Md

Spec.—8-24-14—M. & T.—2000 Bks.

D10979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10979

CERTIFICATE OF DEATH.

150

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 603 Ashburton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Howard Baumann Jr

(Residence in Baltimore: No. 603 Ashburton St.; 0 yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. Oct 22, 1917 (Month) (Day) (Year)

7-AGE. 0 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore City Md

PARENTS.

10-NAME OF FATHER. William Howard Baumann

11-BIRTHPLACE OF FATHER (State or Country). City

12-MAIDEN NAME OF MOTHER. Lula Caudrop

13-BIRTHPLACE OF MOTHER (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Baumann

(Address) 603 Ashburton

15-

Filed....., 191.....

.....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1917, to Dec. 16 1917, that I saw h[illegible] alive on Dec 16 1917 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Imperfect Closure of the Valves of the Heart

(Blue Baby)

(Duration) ....yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Chas H Barbert, M. D.

Dec 17, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park | DATE OF BURIAL. Dec. 18..., 1917.

20-UNDERTAKER Ger. Kehoe & Son | ADDRESS 253 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10980

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Hunke

(Residence in Baltimore: No. 508 N. Belmont Ave St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, February 9, 1908
(Month) (Day) (Year)

7-AGE, 9 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Hunke

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Paulsen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28 1917 to Dec 16 1917, that I saw h[illegible] alive on Dec 16 1917, and that death occurred, on the date stated above, at 10 30 p.m.

The CAUSE OF DEATH* was as follows:

Epidemic Meningitis

..... (Duration) ....yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration) ....yrs. ....mos. ? ds.

(Signed) J. M. Rogers M. D.

Dec 17, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 19 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 508 N. Belmont Ave

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, Dec 18, 1917.

20-UNDERTAKER Christian Miller ADDRESS 233 Hillsdale St

D10981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10981

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Loudon Pier ... St.: 1 WARD) REGISTERED No. C

2-FULL NAME George W. Oberg

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer N. S. Y.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country), Alabama

PARENTS.

10-NAME OF FATHER, J. W. Oberg

11-BIRTHPLACE OF FATHER (State or Country), Sweden

12-MAIDEN NAME OF MOTHER Marie Svendsen

13-BIRTHPLACE OF MOTHER (State or Country), Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Brown

(Address) 175 E 7yr N Y

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Dorsey M. D. (Coroner.)

Dec 17, 1917 (Address) 1210 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mobile Ala | DATE OF BURIAL, Dec 17, 1917

20-UNDERTAKER Stewart & Mowera | ADDRESS 1080 N. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D10982

HEALTH DEPARTMENT--CITY OF BALTIMORE

D10982

CERTIFICATE OF DEATH

170

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 1804 W. Franklin St ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Brentspacher

(Residence in Baltimore: No. 1804 W. Franklin St St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 31, 1868 (Month) (Day) (Year)

7-AGE: 48 yrs. 11 mos. 16 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Legion House

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Geo E Brentspacher

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Sarah E Wollenden

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E Brentspacher

(Address) 1804 W. Franklin St

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 17th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1917, to Dec 17th 1917, that I saw him alive on Dec. 16th, 1917, and that death occurred, on the date stated above, at 10.50 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) One yrs. ..... mos. ..... ds

Contributory (SECONDARY) Uraemia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Herbert L Hellman M. D.

Dec 17, 1917 (Address) 122 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Dec 19th, 1917

20-UNDERTAKER: Putnam & Gore — ADDRESS: 1723 W Lafayette Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D10983 1 3 / 2 5 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D10983

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 733 Dolphin St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Lupton

(Residence in Baltimore: No. Harrisonburg, Va. St.; yrs., 3 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, ..., (Month) (Day) 1852 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John N. Portlock

(Address) 635 N. Gilmore Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia of Left Lung

Metastasis of Liver

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Harrisonburg Va — DATE OF BURIAL, Dec 15, 1917

20-UNDERTAKER J. O. Mitchell — ADDRESS 1201 W Baltimore St

Spec.—8-24-14—M. & T.—3000 Bks.

D10984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Eutaw Place, St.; 14 WARD) REGISTERED NO. C 80

2-FULL NAME Samuel Rosenthal,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1905 Eutaw Place, St.; Lifetime yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male,

4-COLOR OR RACE. White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jany. (Month) 6th. (Day), 1855, (Year)

7-AGE, 62 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clothing
(b) General nature of industry, business, or establishment in which employed (or employer). Mnfg.

9-BIRTHPLACE, (State or Country), Balto.Md.,

PARENTS.

10-NAME OF FATHER, Sigmund Rosenthal,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Bettie Hahn,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosenthal,

(Address) 1905 Eutaw Place,

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 16, (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Dec 16 1917, that I saw h was alive on Dec 16 1917, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senesc. Arteno Sclerosis (Duration) 3 yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 16, 1917 (Address) 1820 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oheb Shalom, DATE OF BURIAL, Dec. 18th 1917

20-UNDERTAKER Harris Friedheim ADDRESS 1188 W Pratt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10985

CERTIFICATE OF DEATH.

92 D10985

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Linden Ave. St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Reiss

(Residence in Baltimore: No. 1601 Linden Ave. St.; 78 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, April 20, 1831 (Month), 1 (Day), ... (Year)

7-AGE, 86 yrs. 6 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Prince George Co., Md.

PARENTS.

10-NAME OF FATHER, John Read Magruder

11-BIRTHPLACE OF FATHER (State or Country), Annapolis Md.

12-MAIDEN NAME OF MOTHER Eliza Waring

13-BIRTHPLACE OF MOTHER (State or Country), Prince George Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Linwood W. Collins

(Address) 1306 Ellamont Ave.

15-

Filed....., 191.....

J. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 16th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10th 1917, to Dec 16 1917, that I saw h[er] alive on Dec 16 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 1 yrs. 2 mos. ..... ds.

(Signed) Joseph C Guthrie M. D.

Dec 17, 1917. (Address) 1516 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Greenmount Cemetery	12/18, 1917
20-UNDERTAKER Henry W. Mears & Son	ADDRESS 805 N. Calvert St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10986

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Bell McCormick

(Residence in Baltimore: No. Church Home & Inf. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept. (Month) 30 (Day) 1867 (Year)

7-AGE.	If LESS than 1 day,
50 yrs. 2 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Alex. McCormick

11-BIRTHPLACE OF FATHER (State or Country), Scotland.

12-MAIDEN NAME OF MOTHER Jane Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John McCormick

(Address) Cordova Md.

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 17 1917, that I saw h[illegible] alive on Dec 191., and that death occurred, on the date stated above, at 6:A, m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

Cerebral hemorrhage (Contributory)

Duration—Immediate terminal (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(Duration) ..... yrs. ..... mos. Five minutes ds.

(Signed) Pat A Foster M. D.

Dec 17, 1917. (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 10 ds. In the State .....yrs. ..... mos. 11 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Cordova Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cordova Md.	Dec 18, 1917

20-UNDERTAKER	ADDRESS
W. A. F. Lynn	142 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10987

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 Wordyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Savard Guy

(Residence in Baltimore: No. 1331 Wordyear St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Dec 11, 1917
(Month) (Day) (Year)

7-AGE, ...yrs.....mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, William Guy

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Stines

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J Guy

(Address) 1331 Wordyear St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 191 7, to Dec 17 191 7, that I saw him alive on Dec 16 191 7, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(8 mo's Baby)

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) E. William [illegible] M. D.

Dec 17, 191 7 (Address) 1928 Pennsylvania

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
A.M.E. Peters	Dec 18 1917

20-UNDERTAKER	ADDRESS
Edward Ringgold	1863 N Carey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10988

CERTIFICATE OF DEATH.

64 D10988

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 W Mt Royal Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate E. Carter

(Residence in Baltimore: No. 1429 W Mt Royal St.; VV yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... June (Month) 15 (Day), 1836 (Year)

7-AGE, 81 yrs. 6 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Jimin

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Marston

(Address) 1429 W Mt Royal

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... December (Month) 16 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 191..., to Dec 16 191..., that I saw h... alive on December 16 191..., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Green Mount

DATE OF BURIAL, Dec 19, 191...

20-UNDERTAKER William Cook

ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10989

CERTIFICATE OF DEATH.

19 D10989

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Fairmount Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel B. Hicks

(Residence in Baltimore: No. 1428 Fairmount Ave ST.; 9/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Oct 26 (Month), 1907 (Day) (Year)

7-AGE, 10 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): School Girl

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Harry Hicks

11-BIRTHPLACE OF FATHER (State or Country), Sowing Baltimore

12-MAIDEN NAME OF MOTHER Irene Simms

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) by Mother Irene Hicks

(Address) 1428 Fairmount Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1917, to June 17 1917, that I saw h[illegible] alive on June 17 1917, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

(b) Empyema

(c) Bronchial Asthma

(Duration) 2 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Bright's Disease

(Duration) 2 yrs. 5 mos. ds.

(Signed) D. G. A. Kennard M. D.

June 18, 1917. (Address) 708 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, June 18, 1917

20-UNDERTAKER Wm R Elliott

ADDRESS 504 East

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 D10990

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 Enon Alley St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Crawford

(Residence in Baltimore: No. 141 Enon alley St.: yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ..., 1890
(Month) (Day) (Year)

7-AGE. 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Hostler
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Crawford

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rosa Clifford

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Crawford

(Address) 141 Enon Alley

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 16 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Epilepsy

..... (Duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Epilepsy

..... (Duration) 1 yr. ..... mos. ..... ds.

(Signed) Edw. V. Fitzgerald M. D.

Dec 17, 1917. (Address) 1118 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetary

DATE OF BURIAL, Dec 18, 1917.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 704 East

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N Stricklen ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teshe Duckett

(Residence in Baltimore: No. 1319 Stricklen St.; 9 mo yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, May 20, 1914 (Month) (Day) (Year)

7-AGE, 3 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or estsblishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Samuel Duckett

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Hawkins

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Duckett

(Address) 1319 Stricklen St

15- O.K. ROBERT B. KR...

Filed ..... 191.... Registrar.

Mad 6272

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 16 1917, that I saw h[er] alive on Dec 16 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

(Burns of Face & Body

(Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) E William Frey M. D.

Dec 17, 1917 (Address) 1728 Pa Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leakin — DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER Edward Ruggold — ADDRESS 1463 W Lexington

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10992

CERTIFICATE OF DEATH.

+131

D10992

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hosp ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Baker

(Residence in Baltimore: No. University Hospital St.; ~~yrs.~~, ~~mos.~~ 10 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	married

6-DATE OF BIRTH, Jan 3 7 (Month) (Day), 1879 (Year)

7-AGE, 38 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), W Va.

PARENTS.

10-NAME OF FATHER, J. H. Coontz

11-BIRTHPLACE OF FATHER (State or Country), W Va.

12-MAIDEN NAME OF MOTHER — Shomo

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L E Baker

(Address) Bentonville Va

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 1:10 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy & cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J W Colley M. D.

12/17, 1917. (Address) Walcott, W Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. 9 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bentonville Va

19-PLACE OF BURIAL OR REMOVAL. Riverville Page Co Va DATE OF BURIAL. Dec 18, 1917

20-UNDERTAKER J S B Cook ADDRESS 1003 E Balto St

DEC 18 1917 ROBERT R. CRAWFORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10993

CERTIFICATE OF DEATH.

X54 D10993

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Maher

(Residence in Baltimore: No. Port Allegany, Pa St.; ...yrs., mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) single

6-DATE OF BIRTH, April (Month) 21 (Day), 1887 (Year)

7-AGE, 30 yrs. 7 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Michael Maher

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Letitia Rigney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. R. Micklethwaite, M.D.

(Address) U. P. Y.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1917, to Dec 18 1917, that I saw h im alive on Dec 18 1917, and that death occurred, on the date stated above, at 8 15 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Following Operations

for Splenectomy Dec 8

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(Duration) ...yrs. ...mos. 1 ds.

(Signed) G. R. Micklethwaite M. D.

Dec 18, 1917. (Address) U. P. Y.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 13 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? Pennsylvania

Former or usual residence Port Allegany Pa.

19-PLACE OF BURIAL OR REMOVAL, Port Allegany Pa

DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER Mulhern Cook

ADDRESS 502 E Water

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 18 1917 ROBERT R. KRAUTER REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10994 D10991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables St.: Gulford Ave 21 & 23 WARD) REGISTERED NO. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Catherine Kaupp.

(Residence in Baltimore: No. Home for Incurables St.; ..... yrs., 1 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1845 (Year)

7-AGE, 77 yrs. ..... mos. ..... dys. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Home for Incurables

(Address) Gulford Ave & 21st St.

15-

Filed....., 191.....

Registrar.

DEC 18 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 11.10 Am.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 2 yrs. 10 mos. 1 ds.

CONTRIBUTORY (Secondary) Apoplexy (Cerebral Hem.)

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Walter A. Bacon M. D.

12/17/17, 191... (Address) 100 E. 20th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 25 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence No. Shrieker St

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Dec 18 191...

20-UNDERTAKER H. E. Taylor — ADDRESS 17 St Paul

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10995

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Mol

(Residence in Baltimore: No. 243 S Central Ave St.: 9 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, January, 1915

7-AGE, 2 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Maryland

PARENTS.

10-NAME OF FATHER, Daniel Mol

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Cichetello

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1917, to Dec 18 1917, that I saw h alive on Dec 18 1917, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

January (Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Rivers M. D.

Dec 18, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 243 S Central Ave

19-PLACE OF BURIAL OR REMOVAL, St. Vincents DATE OF BURIAL, Dec 17, 1917

20-UNDERTAKER Wendell Diffenderffer Sons ADDRESS 330 E Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D10996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D10996

REGISTERED No. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Jefferson St.; 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Harris

(Residence in Baltimore: No. 1421 Jefferson St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., (Month) ....., (Day) 1870 (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edman Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam K. Bailey

(Address) 1421 Jefferson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/12/191?, to 12/14/191?, that I saw h[illegible] alive on 12/14/191?, and that death occurred, on the date stated above, at 8.00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Bayne M. D.

12/17/191?. (Address) 425 N. Carolina St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery

DATE OF BURIAL, Dec. 18th, 1917.

20-UNDERTAKER Chas. E. Bailey

ADDRESS 1421 Jefferson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D10997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D10997

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Ludwig

(Residence in Baltimore: No. 2803 N. Howard ave St.; Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. Mar. 15, 1856 (Month) (Day) (Year)

7-AGE. 61 yrs. 9 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Health Department

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Benj. Ludwig

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER C. Daily

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp

(Address) Calvert St.

15-

Filed....., 191.....

Registrar.

DEC 18 1917 FOREST R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 17 1917, that I saw him alive on Dec 17 1917 and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder about

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Posterior Renal Suppression

(Duration) yrs. mos. 4 ds.

(Signed) Edward D. Smith M. D.

Dec 17 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? 2803 N. Howard ave.

Former or usual residence 2803 N. Howard ave.

19-PLACE OF BURIAL OR REMOVAL, Western Cem DATE OF BURIAL, Dec 20, 1917.

20-UNDERTAKER M. Fahey & Sons ADDRESS 606 Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D1099S

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1099

1-PLACE OF DEATH St Vincents Inf-Asylum 14 91

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gabrielle Vincent

(Residence in Baltimore: No. 1401 Division St.; yrs. 1 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Wht	Single

6-DATE OF BIRTH, Not Known. (Month), 1 (Day), (Year)

7-AGE, abt 2 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None,

9-BIRTHPLACE, (State or Country), Unknown.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. F. Rousseau

(Address) 1219 Madison Ave

15-

Filed....., 191.....

Registrar.

DEC 18 1917

ROBERT M. KRAUTZ
SOCIAL EXPERT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month), 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 16 1917, that I saw her alive on Dec 16, 1917, and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia,

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Edward M. C. Parker M. D.

....., 191... (Address) 1211 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Not Known.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Dec. 20, 191..

20-UNDERTAKER M Fahey & Son ADDRESS 606 E. Lanvale St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D10999

CERTIFICATE OF DEATH.

89 D10999

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N Carolina St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Harris (Harris)

(Residence in Baltimore: No. 612 N. Carolina St.; 1yr. 1mos. 6ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Nov 11 1916, 1 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Harris

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sarah Henson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sarah Harris

(Address)..... 612 N Carolina

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 17 1917, that I saw h[illegible] alive on Dec 14 1917, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

.....

.....

..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) W. C. Burns M. D.

Dec 19 1917 (Address) 2116 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. [redacted] at Auburn

DATE OF BURIAL. Dec 19.. 1917

20-UNDERTAKER John W Henderson

ADDRESS 317 Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

D11000

HEALTH DEPARTMENT—CITY OF BALTIMORE

103 D11000

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Division ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malinda Pope

(Residence in Baltimore: No. 1206 Division St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 10 (Day), 1849 (Year)

7-AGE, 68 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 103

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Chas. R. Gross

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Emmaline Tynes

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... James E. Pope

(Address)..... 1206 Division

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) - 17 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 6-45 p m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

..... (Duration)..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Syncope

..... (Duration)..... yrs. ..... mos. ..... ds.

(Signed) J. Bernard Hughes M. D.

Dec 17, 1917. (Address) 1103 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Smithfield, Va. DATE OF BURIAL, Dec. 19, 1917

20-UNDERTAKER Jno. A. Bishop ADDRESS 1607 Druid Hill Av.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Hahnemann Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian D Vogt

(Residence in Baltimore: No. 605-E. 41st St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—PRINTING NOT ACCEPTABLE

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 25 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Coroner)

....., 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

605 E. 41st St.

Former or usual residence. 605 E. 41st St.

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec. 20, 1917.

20-UNDERTAKER Wm Cook

ADDRESS 502 E. North Ave

DEC 13 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1102

CERTIFICATE OF DEATH.

D1102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E. Linwood Ave St. 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Stenzel

(Residence in Baltimore: No. 117 E. Linwood Ave St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem. 4-COLOR OR RACE, white 5-~~SINGLE,~~ MARRIED, ~~WIDOWED,~~ OR ~~DIVORCED.~~ (*Write* the word.) Married

6-DATE OF BIRTH, Dec 21, 1876 (Month) (Day) (Year)

7-AGE, 41 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary McMenamin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. K. Kelly M.D.

(Address) 100 N. Linwood Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis of Mitral Regurgitation

Chronic Parenchymatous Nephritis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration).....yrs.....mos.....ds.

(Signed) B. K. Kelly M. D.

Dec 16, 1917. (Address) 100 N. Linwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL, 12/19..., 1917.

20-UNDERTAKER J. A. Moran ADDRESS 9000 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 21003

REGISTERED No. C 64 D 21003

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 440 St. Mary's St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Jenkins

(Residence in Baltimore: No. 440 St. Mary's St.; yrs. 46 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col.	Widower

6-DATE OF BIRTH, Unknown, (Month) (Day) 1866 (Year)

7-AGE, 51 yrs. Unknown mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer). 040

243

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Dixon

(Address) 440 St. Mary's

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
(Primary) Died Sudden
Chronic Nephritis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 17, 1917. (Address) 819 Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem.	Dec. 17, 1917

20-UNDERTAKER	ADDRESS
George H. Holland	631 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1004

CERTIFICATE OF DEATH.

92 D1004

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Baker W ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H Bailey

(Residence in Baltimore: No. 725 Baker St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, [illegible] ....., 1872
(Month) (Day) (Year)

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Florist

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Bailey

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmira Bailey

(Address) 725 Baker St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1917, to 12/16 1917, that I saw h[illegible] alive on 12/16 1917, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Ex Tuberculosis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. B. Lusk Battle M. D.

12/18, 1917. (Address) 211 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, Dec 19, 1917

20-UNDERTAKER Jno H Holland

ADDRESS 1631 Druid Hill Ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11005

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D11005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 Mulberry ST.; 17 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R Brooks

(Residence in Baltimore: No. 1246 Mulberry St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October 18, 1869
(Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 19 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housewife

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Alexander Bradley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Etta Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Brown

(Address) 1246 Mulberry St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 29 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 11.25 A.M.

The CAUSE OF DEATH* was as follows:

.....

.....

Sub Pontal Abscess (Puerperal)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) 1 yrs. 10 mos. ..... ds.

(Signed) Wm R Wagner M. D.

Dec 18, 1917. (Address) 1209 Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Dec 21st, 1917

20-UNDERTAKER Clarence Haugh

ADDRESS 1384 W Cary

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1400G

D1400G

CERTIFICATE OF DEATH.

150X

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Perkins

(Residence in Baltimore: No. 1 mo. 12 days St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH, ..., 1910.
(Month) (Day) (Year)

7-AGE, ...7....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Perkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. J. Smyth

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 191 7 to Dec. 16 191 7, that I saw her alive on Dec. 16 191 7, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, Congenital & Instructive

..... (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of heart

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) R. P. Batchelor M. D.

Dec. 17, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Easton, Md.

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, Dec. 19, 191..

20-UNDERTAKER Casmore & Wright ADDRESS Govans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D1107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1107

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728. Fleet ST.; V WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bezezinski

(Residence in Baltimore: No. 1728. Fleet St St.; ..... yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 28 (Day), 17 (Year)

7-AGE, ... yrs. 20 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Brzezinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josefa Frick

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Brzezinski

(Address) 1728 Fleet St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 11 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-10 191?, to 12-11 191?, that I saw h alive on 12-? 191?, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

..... Broncho Pneumonia

..... Primary ..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Heart Failure

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) H. D. Aisbitt M. D.

12-13, 191.. (Address) 1421 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, Dec 13, 191..

20-UNDERTAKER Wm Fairfowl & Co ADDRESS 1618 Eastern Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 18 1917 ROBERT B. KRAUSER Burial Permit Clerk

W 4996

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11008

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 8 Light St.Wharf. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W.Broadway(C)

(Residence in Baltimore: No. Pier 8 Light St.Wharf. St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH, ..Do not know.. (Month) ..... (Day) 1 (Year)

7-AGE, 54 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Deck hand on
(b) General nature of industry, business, or establishment in which employed (or employer): Steamer.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Broadway.(C) son.
(Address) 630 Jasper St.

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 16th. 1917., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M Kennard M. D.
(Coroner.)

Dec. 17th 1917. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 18 ....., 191.7
20-UNDERTAKER	ADDRESS
L. V. Fusselbaugh	2620 St Paul St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11009

CERTIFICATE OF DEATH.

X24 D11009

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Funkgraft

(Residence in Baltimore: No. West Fayette St.; yrs., mos. 3 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... December (Month) ..... (Day) ....., 1885 (Year)

7-AGE, 32 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Funkgraft

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sarah Funkgraft

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Wm. M. Stein .....

(Address) ..... Emmitt Apts .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 12 (Month) ..... 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-15 1917, to 12-18 1917, that I saw h— alive on 12-17 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

..... 1. Cirrhosis (Int-acute)

.....

.....

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12/17, 1917 (Address) Eleventh & Hoyt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence West Fayette St Md.

19-PLACE OF BURIAL OR REMOVAL, Westminster Md. DATE OF BURIAL, Dec. 19, 1917

20-UNDERTAKER Wm Cook ADDRESS 552 E Fayette

DEC 18 1917 ROBERT N. KRAUTER Burial Permit Clerk

(over)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11010

CERTIFICATE OF DEATH.

108 D11010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 Pierce ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Green

(Residence in Baltimore: No. 673 Pierce St.; 12 yrs., 2 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sep (Month) 23 (Day), 1905 (Year)

7-AGE, 12 yrs. 2 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Primary School
(b) General nature of industry, business, or establishment in which employed (or employer): 40

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Houston Green

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Delphine Blake

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lizzie Stewart

(Address) 673 Pierce st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 17 1917, that I saw her alive on Dec 16 1917, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) None

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) R B Kempton M. D.

Dec 17, 1917 (Address) 422 N Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn cemetery

DATE OF BURIAL, Dec 19, 1917

20-UNDERTAKER Felix B. Pyle

ADDRESS 102 E. Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11011 D11011

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christopher Green

(Residence in Baltimore: No. Middlebrook Ave. St.; yrs., mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1895 (Month) (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, George H. Green

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records at Univ. Hospital

(Address) .....

15-

Filed....., 191.....

Registrar.

DEC 18 1917 ROBERT R. REACTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia following Gun shot Wound in Arm (accidental)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Driscoll M. D. (Coroner)

Dec 17 191... (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Baltimore, Md. In the

of death ..... yrs. ..... mos. 3 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Millenbeck Va

DATE OF BURIAL, Dec 19 191...

20-UNDERTAKER Jos B Cook

ADDRESS 1003 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

DL1012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 DL1012

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Goszka.

(Residence in Baltimore: No. 2914 Hudson St.; 27 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 30 (Day), 1885 (Year)

7-AGE, 32 yrs. 1 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Stanislaus Goszka.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Mary Grembocka.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Goszka.

(Address) 2914 Hudson St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 16 1917, that I saw h[illegible] alive on Dec 16 1917, and that death occurred, on the date stated above, at 3.20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) T. Tuberculosis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) W. F. Burke M. D.

Dec 17, 1917. (Address) 3042 Hudson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, Dec 20, 1917

20-UNDERTAKER M. F. Sadowski ADDRESS 905 S. Ann St

Spec.—8-24-14—M. & T.—2000 Bks.

D11013

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D11013

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Calvert ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME America Semmes Payne.

(Residence in Baltimore: No. 1319 N. Calvert St ST.; 8 yrs., mos. ~~ds.~~)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single.

6-DATE OF BIRTH, ... Feby (Month) 22nd (Day), 1865. (Year)

7-AGE, 52 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cut Home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Warrenton Va.

PARENTS.

10-NAME OF FATHER. Rice W. Payne

11-BIRTHPLACE OF FATHER (State or Country) Warrenton Va.

12-MAIDEN NAME OF MOTHER Virginia Semmes

13-BIRTHPLACE OF MOTHER (State or Country) Georgetown D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Columbus Shriver.

(Address) 1319 N. Calvert St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 17th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9th 1917, to Dec 17th 1917, that I saw h er alive on Dec 17th 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....Labor Premature.....

..... (Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Colitis and Enteritis (Duration) Many yrs.....mos.....ds.

(Signed) Thomas L. Sheary M. D.

Dec. 18, 1917. (Address) 905 N. Clarke St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Warrenton Virginia

DATE OF BURIAL, "Dec 19", 1917.

20-UNDERTAKER Henry H. Jenkins & Sons Co

ADDRESS 1116 Eutaw & Orchard Sts.

Spec.—5-19-13—M. & T.—500 Bks.

D11014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11014

CERTIFICATE OF DEATH.

79

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3055 Brighton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Agnes Boland

(Residence in Baltimore: No. 3055 Brighton St.; 27 yrs., 1 mos. 13 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Nov. 2, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. 1 mos. 13 ds.

If LESS than 1 day, ... hrs. or ... min.? X

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Graduate Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Nurse 048

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Johan Boland †

11-BIRTHPLACE OF FATHER (State or Country), Balto. City.

12-MAIDEN NAME OF MOTHER Barbra E. Bolte

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara E. Boland

(Address) 3055 Brighton St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1917, to Dec 1917, that I saw her alive on Dec 15th 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
supervenduced by enlargement
of heart (Sup. Acute Nephritis)
(Duration) 8 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Syncope
(Duration) X yrs. X mos. 4 ds.

(Signed) P. S. Hutchison M. D.

12-17-17, 191.. (Address) 1939 Gilmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Dec. 19, 1917

20-UNDERTAKER Mr. & Mrs. John W. Teufel

ADDRESS 801 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11015

CERTIFICATE OF DEATH.

107

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Dellwood Ave. St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen A. King

(Residence in Baltimore: No. 1222 Dellwood Ave. St.; ... yrs., ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION Dangerous important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Dec. (Month) 16 (Day), 1916 (Year)

7-AGE, 1 yrs. — mos. 1 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Robert H. King

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nellie A. Giles

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. King

(Address) 1222 Dellwood Ave.

15-

Filed ..., 191...

Registrar.

13

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1917, to Dec 17th 1917, that I saw h[er] alive on Dec 17th 1917, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Contributory)

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) 2

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

12-16-, 1917. (Address) 1127 Linwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Rovans — DATE OF BURIAL, Dec. 19.., 1917

20-UNDERTAKER Horace Burgee & Son — ADDRESS 1631 Falls Road.

Spec.—5-19-13—M. & T.—500 Bks.

D11016 HEALTH DEPARTMENT—CITY OF BALTIMORE D11016

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 243 Camel ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James monroe Smith

(Residence in Baltimore: No. 243 Camel Street St.; yrs. 4 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	Black	Single

6-DATE OF BIRTH. August (Month) 26 (Day); 1917 (Year)

7-AGE. — yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE. (State or Country) Balto. City.

PARENTS.

10-NAME OF FATHER. William Smith

11-BIRTHPLACE OF FATHER (State or Country). Balto. City.

12-MAIDEN NAME OF MOTHER Etta Broadway

13-BIRTHPLACE OF MOTHER (State or Country). Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Broadway

(Address) 243 Camel stuet.

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December - 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec - 14 - 1917, to 1917.

that I saw h m alive on Dec. 14 1917.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Paralysis - Embolism

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Chesshire M. D.

12 Oct. 1917. (Address) 2217 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Dec 19, 191.7

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa - Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11017 HEALTH DEPARTMENT—CITY OF BALTIMORE D11017

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 685 Josephine ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Robison

(Residence in Baltimore: No. 685 Josephine St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... October (Month) ..... 1 (Day) ..... (Year)

7-AGE, 23 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 1411

PARENTS.

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Rollin Robinson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Helen Blue

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Robison

(Address) 685 Josephine

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 16 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. D. Davidson M. D.
(Coroner)

Dec 17 1917 (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec 20 1917
20-UNDERTAKER	ADDRESS
Daniel Easton	916 Pa - ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

DEC 18 1917 CHAS. E. FOSTER

D.

Spec.—8-24-14—M. & T.—2000 Bks.

D11018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11018

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Keys

(Residence in Baltimore: No. 1620 Pierce St

St.: .....yrs., ...mos. .....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH. July 7, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Susie Keys

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1917, to Dec 17 1917, that I saw h alive on Dec 17 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal infection, acute

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) malnutrition

(Duration) ? yrs. — mos. — ds.

(Signed) J. M. Rivers M. D.

Dec 18, 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 1 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?....

Former or usual residence 1620 Pierce St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 18, 1917

20-UNDERTAKER Brown & Cleveland — ADDRESS 1144 E. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11019

CERTIFICATE OF DEATH.

167 D11019

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1511 Lemmon ST.: 19 WARD)

2-FULL NAME Zelda Broomes

(Residence in Baltimore: No. 1511 Lemmon St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH. Oct (Month) 10 (Day), 1915 (Year)

7-AGE. 2 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm Broomes

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Martha Harris

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Broomes

(Address) 1511 Lemmon

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 16, (Day) 1917. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, an (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Scald 7 Chest burns accidental (Duration) ....yrs. ....mos. 6 ds.

(Signed) James M Kerlin M. D. (Coroner.)

Dec 18. 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Dec 18 1917
20-UNDERTAKER	ADDRESS
Brown & Heeland	Schroeder St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B

Spec.—5-19-13—M. & T.—500 Bks.

D11020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11020

CERTIFICATE OF DEATH.

REGISTERED No. C 3

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Greenmount Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John O Chilcote

(Residence in Baltimore: No. 3023 Greenmount av St.; 45 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 25 (Day), 1868 (Year)

7-AGE, 49 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER, John R Chilcote

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER Mary E Cole

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine R Chilcote

(Address) 3023 Greenmount Av

15-

Filed....., 191....

C3 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1917, to Dec 17 1917, that I saw him alive on Dec 17 1917, and that death occurred, on the date stated above, at 7 38 p m.

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) Joseph E. Wm. M. D.

Dec 18 191 7 (Address) 520 Holliday St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL. Dec 21, 1917

20-UNDERTAKER Robt S. Littles — ADDRESS 531 N Fremont Av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D1021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1021

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 North Fremont Street St.: 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archibald McElmoyle

(Residence in Baltimore: No. 916 North Fremont Street St.: 70 yrs.. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. Feb. 27, 1829 (Month) (Day) (Year)

7-AGE. 88 yrs. 9 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): (Coal dealer)

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, James McElmoyle

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Elizabeth S. McNeill

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Belle Kohler 916 Fremont St

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1914, to Dec 18 1917, that I saw him alive on Dec 17 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
Acute Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12/18, 1917. (Address) 1622 Eutaw Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL, Dec 20 1917

20-UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Ave

D11022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D11022

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 330 St. Paul St.; WARD) 4

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Stucht

(Residence in Baltimore: No. 330 St Paul St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June 24, 184[illegible] (Month) (Day) (Year)

7-AGE, 75 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ~~ABOVE~~ IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret B. Stucht

(Address) 330 St Paul

15-

Filed....., 191.....

B. Registrar.

DEC 18 1917 ROBERT A. RESLEWIS Special Deputy Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) None

(Duration).....yrs.....mos.....ds.

(Signed) A. D. Driscoll M. D. (Coroner.)

Dec 17, 1917. (Address) 121 Milberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Dec 20 1917

20-UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. North Ave

D11023

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D11023

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 507 N. Bond St.: 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Moore

(Residence in Baltimore: No. 507 N. Bond St.: yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Col	Single

6-DATE OF BIRTH: Jan (Month) 10 (Day), 1849 (Year)

7-AGE: 18 yrs. 10 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Day Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 640

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Albert moore

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Clara Slyerter

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Moales

(Address) 507 N. Bond St

15.

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 16 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2 , 1917 , to. Dec 14 1917 ,
that I saw h[illegible] alive on Dec. 14 , 1917 ,
and that death occurred, on the date stated above, at [illegible] m.
The CAUSE OF DEATH* was as follows:

Pulm - Tuberculosis

(Duration) ..... yrs. 3 mos. ..... ds

Contributory (SECONDARY) Cardiac Asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. C. Reed M. D.

12 , 191 7 (Address) 16 Hurst St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Dec 19 1917

20-UNDERTAKER: Milton Davis — ADDRESS: 413 N. Eden St

D11021

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/21/20

91 D11021

REGISTERED NO. C .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 421 E. 21st St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Minerva S. McCleary

(Residence in Baltimore: No. 421 E 21st St. 70 yrs. 3 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH Oct. 6, 1847
(Month) (Day) (Year)

7-AGE 70 yrs. 3 mos. 11 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) York Co. Pa.

PARENTS

10-NAME OF FATHER David Williams

11-BIRTHPLACE OF FATHER (State or country) Maryland.

12-MAIDEN NAME OF MOTHER Sarah Rossell

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence McCleary

(Address) 421 E 21st St

15

Filed ....., 191.... 8 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec. 11, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1917, to Dec 11th 1917, that I saw h[illegible] alive on Dec 11th 1917, and that death occurred on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Complicated with a gangrene in a boil.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Edema of Lungs

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Eugene Forsythe M. D.

Dec 17, 1917 (Address) 1000 Hunt Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Freelands Md | DATE OF BURIAL Dec 19 1917

20-UNDERTAKER E. LeRoy Stiffler | ADDRESS 3144 W 36th St

Spec.—8-24-14—M. & T.—2000 Bks.

D11025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11025

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N. Fremont Ave ST.: 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genevieve Rowell

(Residence in Baltimore: No. 833 N Fremont Ave St.; — yrs., — mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Nov 30, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Berry A. Rowell

11-BIRTHPLACE OF FATHER (State or Country), Pittsburg Pa

12-MAIDEN NAME OF MOTHER Ida Meerstein

13-BIRTHPLACE OF MOTHER (State or Country), Wisconsin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Meerstein Rowell

(Address) 833 N. Fremont Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1917, to Dec 18 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Mouth & Throat & Chest

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) James T. Rivers M. D.

Dec 18, 1917. (Address) 804 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westerns — DATE OF BURIAL, Dec 19, 1917.

20-UNDERTAKER H C Brauning Sons — ADDRESS 517 N Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

11026

HEALTH DEPARTMENT—CITY OF BALTIMORE

11026

CERTIFICATE OF DEATH.

37

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Emma A Dornee

(Residence in Baltimore: No. 702 N Carey St.; Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec 5th, 1883
(Month) (Day) (Year)

7-AGE, 34 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, — Whitman

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Dornee

(Address) 702 N Carey St

15-

Filed....., 191.....

B. Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12th 1917, to Dec 17th 1917, that I saw her alive on Dec 17th 1917, and that death occurred, on the date stated above, at 7 50 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Cancer (?)

(Duration) 6 yrs. about mos. ds.

(Signed) John H Montgomery M. D.

Dec 17th 1917. (Address) 1300 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 4 mos. 13 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? Dont Know

Former or usual residence 702 N Carey St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Western	12-21., 191.7
20-UNDERTAKER H C Brauning & Son	ADDRESS 517 N Howard St

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Spec.—8-24-14—M. & T.—2000 Bks.

D11027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D11027

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Elm ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Knauff.

(Residence in Baltimore: No. 1920 Elm St. Rosedale St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, December 16th, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Knauff

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Annie Corbett

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Knauff

(Address) 1920 Elm St.

15-

Filed....., 191.....

Registrar.

13.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 16 1917, to Dec 18 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

This baby seemed all right at birth. Dec 16/17 - then seemed to grow old became jaundiced - Refused to nurse & died in 3 days

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Pharmacy

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. W. Brown M. D.

Dec 18, 191.. (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem

DATE OF BURIAL, Dec 19, 191..

20-UNDERTAKER W. M. Gaulbert

ADDRESS 1624 Mt Roy at. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.I.1023

CERTIFICATE OF DEATH.

92 D.I.1023

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Aisquith ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie B. Birch

(Residence in Baltimore: No. 926 Aisquith St.: 29 yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 29, 1888
(Month) (Day) (Year)

7-AGE, 29 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph J. Herring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Julia Hornick

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Peter R. Birch

(Address) 926 Aisquith St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1917, to Dec. 16, 1917, that I saw h[illegible] alive on Dec. 16, 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs...mos. 6 ds.

CONTRIBUTORY (Secondary) Fatty Degeneration of the heart

(Duration) one yrs....mos....ds.

(Signed) F. J. Fields M. D.

Dec. 16, 1917. (Address) 1001 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Dec. 20, 1917

20-UNDERTAKER Henry Horn & Son — ADDRESS 121 E Eager St.

DEC 19 1917 ROBERT B. KRAUSER DEPUTY REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

B11023

HEALTH DEPARTMENT—CITY OF BALTIMORE

B11023

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Surviving Chd Madison ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Baby Birch

(Residence in Baltimore: No. 926 Aisquith St.; ....yrs.,....mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Dec. 15 (Month) 1917 (Day) ? (Year), 1

7-AGE, ...yrs....mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Peter R. Birch

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Annie B. Herring

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Peter R. Birch

(Address) 926 Aisquith St

15-

Filed....., 191.....

Registrar.

DEC 19 1917 ROBERT R. KRAUSE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 14 1917, to Dec. 15 1917, that I saw h.. alive on Dec. 15 1917, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration).....yrs.....mos.....ds.

(Signed) Dr. J. E. Robert M. D.

....; 191... (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 2 ds. In the State....yrs....mos. 2 ds.

Where was disease contracted, if not at place of death? 926 Aisquith St.

Former or usual residence 926 Aisquith St

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Dec. 20, 191.7.

20-UNDERTAKER Henry Hoeck's Son — ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11030 · 91 D11030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Holbrook ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Connaughton

(Residence in Baltimore: No. 1511 Holbrook St.; 52 yrs., \ mos. \ ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Not Known ....., 1 ..... (Month) (Day) (Year)

7-AGE, over 75 yrs. \ mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Brennan

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Burns

(Address) 1511 Holbrook St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Hanlon M. D.

Dec. 18 1917 (Address) 1018 E Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Dec. 21, 1917

20-UNDERTAKER Henry Hock & Son

ADDRESS 1301 E Lanvale St

Spec.—8-24-14—M. & T.—2000 lks.

D11031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x53 D11031

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Heinrich

(Residence in Baltimore: No. 4 days Johns Hopkins Hosp. St.: ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec. 26, 1878
(Month) (Day) (Year)

7-AGE, 38 yrs. 11 mos. 22 ds.

If LESS than 1 day, ... hrs. or ... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mining Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

953

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Caspar Joseph Heinrich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER H. Bertha Roesleyn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ...

(Address) Johns Hopkins Hospital.

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1917, to Dec. 15 1917, that I saw him alive on Dec. 15 1917, and that death occurred, on the date stated above, at 7:50 p.m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ... yrs. ... mos. 4 ds.

(Signed) Alb Blumer M. D.

Dec. 19, 1917. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 4 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Lincolnton Georgia

19-PLACE OF BURIAL, OR REMOVAL, London Park — DATE OF BURIAL, Dec. 19, 1917

UNDERTAKER Jno B. Cook — ADDRESS 1103 W Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Thomas E. Strean

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11032

CERTIFICATE OF DEATH.

D11032

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5th Gen. Hospital St., 16 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Thomas E. Strean

(Residence in Baltimore: No. 720 N. Vincent St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, January, 1895
(Month) (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter 023
(b) General nature of industry, business, or establishment in which employed (or employer): Saloon

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Benj. Strean

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Duncan

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) 720 N. Vincent

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis
(b) Caused from Alcoholism
(c) .....
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
....., 191.., (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn | DATE OF BURIAL, DEC 18 1917, 19....

20-UNDERTAKER, James H. Dennis | ADDRESS 1303 Prestman St.

DEC 19 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D11033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11033

175

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Wilhelm ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Newman

(Residence in Baltimore: No. 1808 Wilhelm St.; 42 yrs. 7 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the Word.)
Fem	White	Married

6-DATE OF BIRTH, ... Nov (Month) 1 (Day) ..... (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, John D. Newman

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Louisa Rudroff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Newman

(Address) 1808 Wilhelm St

15-

Filed ....., 191.....

Registrar.

DEC 19 1917 ROBERT R. KRAMER BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 17 1917, that I saw h- alive on Dec 17 1917, and that death occurred, on the date stated above, at 6h m.

The CAUSE OF DEATH* was as followa:

Ac. Interstitial Nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Ed. Wm. Lehman M. D.

12/18/17, 191... (Address) 24 N Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo A Gerber

ADDRESS Balto Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11031 D11031

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. 334 S Stricker ST. 19 WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Claudine Hill

(Residence in Baltimore: No. 334 S Stricker St.; 10 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Dec 28 (Month) (Day), 1842 (Year)

7-AGE, 74 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Cumberland Md

PARENTS.

10-NAME OF FATHER, John Hill

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mc Kinney

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Harry F. Backe

(Address) 1509 Ramsay St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 1917, to DEC 17 1917, that I saw h[illegible] alive on DEC 1- 191[illegible], and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

about 6 Mo. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

Cancer (Duration) yrs. mos. ds.

(Signed) John F Mangor M. D.

DEC 19, 1917. (Address) 1002 Columbia Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cumberland Md

DATE OF BURIAL, Dec 20, 1917.

20-UNDERTAKER Leo A Gerber

ADDRESS Balto & Payson

Spec.—8-24-14—M. & T.—2000 Bks.

D11035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11035

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 S. Paca St. St.; 22 Ward)

REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Rosie Tarsia

(Residence in Baltimore: No. 841 S. Paca St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 24 (Day), 1871. (Year)

7-AGE, 45 yrs. 11 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, do not Know

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER do not Know

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Dimarco

(Address) 226 S. Howard

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 191 7, to Dec 17 191 7, that I saw her alive on Dec 17 191 7, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Luigi D. DiStefano M. D.

Dec. 18 191 7. (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem — DATE OF BURIAL, Dec 20, 191 7.

20-UNDERTAKER John F. Tahey & Sons — ADDRESS 1318 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11036 104 1936

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby. Dickerson

(Residence in Baltimore: No. 924 N. Rutland Ave St.; ..... yrs., ... mos. ..... ds.)

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, September 16, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Nellie Dickerson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917 to Dec 11 1917, that I saw h— alive on Dec 11 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Patent Hypertrophic Stenosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. M. Rynearson M. D.

Dec. 11, 1917 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 924 N. Rutland Ave

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ..., 191...

20-UNDERTAKER ..... ADDRESS .....

DEC 12 1917 JOHNS HOPKINS HOSPITAL

Commissioner of Health.

D11037

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11037

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2417 St Paul St 17 WARD)

2-FULL NAME Rev. Luther T. Wiederman

(Residence in Baltimore: No. 2417 St Paul St.: 61 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6-DATE OF BIRTH March 31, 1840 (Month) (Day) (Year)

7-AGE 77 yrs. 9 mos. 17 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Lhemuel S. Wiederman

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Harriette Hay

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George O. Smith

(Address) 1000 W Fayette st

15

Filed ..... 191 .....

REGISTRAR

DEC 19 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 17, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 A.m Dec, 1917, to 11.0m Dec 1917, that I saw h[illegible] alive on Dec 17, 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chr Myo-Cardite

Probably Some years
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Syncope & Paralysis 2 hours Serious home
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr R T Mifflin M. D.

Dec 18, 1917 (Address) 1916 Mad av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Dec 20 1917

20-UNDERTAKER	ADDRESS
Geo J Smith	1000 W Fayette st

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHEN PERFECT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11038 64 D11038

1 PLACE OF DEATH — Registered No. C .....

CITY OF BALTIMORE (No. Methodist Home for Aged St.: 20 Ward) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura J Orrick

(Residence in Baltimore: No. Methodist Home for Aged St.: 5/12 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June 20 (Month) (Day), 1843 (Year)

7 AGE: 74 yrs. 5 mos. 28 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 608

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Keener Orrick

11 BIRTHPLACE OF FATHER (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary N Yonat.

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E Rebekah Mewshaw
(Address) Home for aged M E Home

15 Filed ....., 191 .....
REGISTRAR

DEC 19 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 18 (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1917, to Dec 18 1917, that I saw h[illegible] alive on Dec 17, 1917, and that death occurred on the date stated above, at 6.30 A m.
The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Agoraphobia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Edmund Rimmon M. D.
Dec 18, 1917 (Address) 709 Harrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cem. | DATE OF BURIAL: Dec 20, 1917

20 UNDERTAKER: Geo J Smith | ADDRESS: 1000 Fayette st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHILE PERMIT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Sec —5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11039

CERTIFICATE OF DEATH.

119 D11039

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 W Lexington ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah L Weedon

(Residence in Baltimore: No. 1306 W Lexington St.; 70 yrs. ... mos. ... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) 28 (Day), 1842 (Year)

7-AGE, 75 yrs. 2 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Public School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country). Talbot Co Md

PARENTS.

10-NAME OF FATHER, John H Weedon

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary A. Townsend

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Ava Weedon

(Address) 1306 W. Lexington

15-

Filed ..., 191...

Registrar.

DEC 19 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th 1917 to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

Chronic

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Nephritis

(Duration) ... yrs. ... mos. 11 ds.

(Signed) M. G. Smith M. D.

Dec 18, 1917 (Address) 118 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Park

DATE OF BURIAL, Dec 20, 1917

20-UNDERTAKER Geo J Smith

ADDRESS 1000 N. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11040

CERTIFICATE OF DEATH.

29 D11040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 W Hill ST.; 27 WARD) REGISTERED NO. C.....

2-FULL NAME Maggie Gross Savage

(Residence in Baltimore: No. 138 W Hill St.; 26 yrs., 7 mos. 28 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	married

6-DATE OF BIRTH, April (Month) 19 (Day), 1891 (Year)

7-AGE, 26 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Operator
(b) General nature of industry, business, or establishment in which employed (or employer): Overal factory

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. Block

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Annie Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Gaines

(Address) 138 W Hill St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1917, to Dec. 17, 1917, that I saw h[er] alive on Dec 17, 1917, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

(a) Pul. Phthisis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

Pul. Congestion

(Duration) yrs. mos. 2 ds.

(Signed) J. Guy Bowden M. D.

12-18, 1917. (Address) 130 W Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	12-20-, 1917
20-UNDERTAKER	ADDRESS
Jno A Loudon	1[illegible]

DEC 19 1917 ROBERT E. KRAUTZ Burial Permit Clerk

D11041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 170 D11041

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 route to St. Joseph ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Ludwig

(Residence in Baltimore: No. Overlea Balto Co, Md St.; yrs., mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 16 (Day), 1902 (Year)

7-AGE, 15 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank J. Ludwig

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Emma Koebler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Ludwig

(Address) Overlea Md

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 17 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Struck on head with Rubber by Bracket (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D. (Coroner.)

Dec 18 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs. 1 mos. ....ds. In the State 16 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetry	Dec 20, 1917
20-UNDERTAKER Wm Cook	ADDRESS 5026 Md Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11042 D11042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 15 Ward)

REGISTERED NO. C 1720

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Schapiro

(Residence in Baltimore: No. 2448 Woodbrook Ave St.; 30 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 15 (Day), 1874 (Year)

7-AGE, 43 yrs. 9 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work General
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Schapiro

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fannie Rosenwasser

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore

15-

Filed ....., 191.... Registrar.

DEC 19 1917 ROBERT R. CRADDOCK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Dec 18 1917, that I saw him alive on Dec 18 1917 and that death occurred, on the date stated above, at 2 00 p. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Endocarditis
Chronic Interstitial nephritis (Duration) Unknown
CONTRIBUTORY (Secondary) Oedema of Lungs (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) B. Israel Hexter M. D.
Dec 18, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 65 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 2448 Woodbrook Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 12-19-, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D11043 HEALTH DEPARTMENT—CITY OF BALTIMORE D11043

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 N. Roe ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly May Frick

(Residence in Baltimore: No. 1211 N. Roe St.; 34 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, November 23, 1883
(Month) (Day) (Year)

7-AGE, 34 yrs. ..... mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman mf
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Louis N. Holland

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Emma V. Brady

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton Frick

(Address) 121 N. Roe St

15-

Filed ....., 191.....

DEC 19 1917 ROBERT R. BEAUTAM Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 16, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 16 1917, that I saw h[illegible] alive on Dec 13 1917, and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

..... Septicaemia .....

....

....

..... (Duration) ... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Wilbur C. Hamer M. D.

Dec 17, 1917. (Address) 16 or 18 W. Mt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Dec 19, 1917

20-UNDERTAKER	ADDRESS
Christian Miller	2534 Jefferson St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11041 D11041

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1718 Aliceanna ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franzis Sienkiewicz

(Residence in Baltimore: No. 1718 Aliceanna St.; ....yrs., 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, October (Month) 10 (Day), 1915 (Year)

7-AGE. ....yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wladyslaus Sienkiewicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Apolonia Romanowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Wladyslaus Sienkiewicz

(Address) 1718 Aliceanna St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 17 1917, to December 17 1917, that I saw h[illegible] alive on December 17 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

.....

.....

Broncho Pneumonia

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ....yrs. ....mos. 5 ds.

(Signed) [illegible] M. D.

December 18 1917. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Dec 19, 191[illegible]

20-UNDERTAKER William Faulkner

ADDRESS 1111 Eastern Ave

Copy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT B. KRAUSE
DEC 19 1917
Burial Permit

Spec.—8-24-14—M. & T.—2000 Blks.

James C. Blair

D11045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11045

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James C. Blair

(Residence in Baltimore: No. 1100 McCulloh St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, April 30, 1911
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, Robt R. Blair

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Dora Ryan

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt R. Blair

(Address) 1100 McCulloh St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 191.., to Dec. 19th 191.., that I saw him alive on Dec. 19th 191.., and that death occurred, on the date stated above, at 5 ff m.

The CAUSE OF DEATH* was as follows:

Tabes - Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, [redacted] Cemetery

DATE OF BURIAL, Dec. 20, 1917

20-UNDERTAKER H M Routson

ADDRESS 230 N Greene

R. C.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

REGISTERED No. C

D11046

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 Dock Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth J. Mahoney

(Residence in Baltimore: No. 945 Greenmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Work

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo Lodering

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth West

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lodering

(Address) 945 Greenmount Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Scalds. Cap 1
Fire while standing
Brain Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	12/16....., 191..
20-UNDERTAKER Henry A. Means & Son	ADDRESS 1057 N. Calvert St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11017

D11017

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 E. Lanvale St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Heineman

(Residence in Baltimore: No. 1406 E. Lanvale St.; ...yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	—

6-DATE OF BIRTH, December (Month) 17 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
...yrs. ...mos. 1½ ds.	...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Karl Heineman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Hilda Elizabeth Dugler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Karl Heineman

(Address) 1406 E. Lanvale St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17 1917, to Dec. 18 1917, that I saw her alive on Dec. 18 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cyanosis Neonatorum

(Duration) ...yrs. ...mos. 1½ ds.

CONTRIBUTORY (Secondary) Premature birth, 7 mos. gestation

(Duration) ...yrs. ...mos. ...ds.

(Signed) W. Ed. Sandrock M. D.

Dec. 19, 1917. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Dec. 19, 1917
20-UNDERTAKER	ADDRESS
Frank H. Tenk	115 E. Gay St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Daisy Brunson

D11018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D11018

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1623 Mulberry St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Brunson

(Residence in Baltimore: No. 1623 Mulberry St.; yrs., 21 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1888 (Year)

7-AGE, 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jackson

(Address) 1623 Mulberry St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sabury Conn. DATE OF BURIAL, Dec. 17, 1917

20-UNDERTAKER Harry A. Vodery ADDRESS 1225 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11049

CERTIFICATE OF DEATH.

40 D11049

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Griffin

(Residence in Baltimore: No. 1512 E Monument St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col. a.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1862 (Year)

7-AGE, 55 yrs. .... mos. .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lloyd Griffin

(Address) 1512 E. Monument St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 17, (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1917, to Dec. 17, 1917, that I saw her alive on Dec. 17, 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) ....yrs. 1 mos. ....ds.

(Signed) J. C. Robinson M. D.

Dec. 18, 1917 (Address) 1520 E. Monument St.

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Dec. 20, 1917

20-UNDERTAKER John E. Owens

ADDRESS 538 Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11050 D11050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 Grundy St ST.; 24 WARD) REGISTERED NO. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn E. Earl (Earl)

(Residence in Baltimore: No. 419 Grundy St St.; ....yrs. ....mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Apr. 27, 1917 (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jno O. Earl

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Olive A. Foxwell

13-BIRTHPLACE OF MOTHER (State or Country), Rochester N.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno O. Earl

(Address) 419 Grundy St

15-

Filed ....., 191.....

Registrar.

DEC 19 1917 ROBERT A. KRAUPEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 18 1917, that I saw h[illegible] alive on Dec 17 1917, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

a b c Pneumonia

(Duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) F. C. Ehrmann M. D.

Dec 18, 1917 (Address) 710 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Cedar Hill Cem

DATE OF BURIAL, Dec 20, 1917.

20-UNDERTAKER E & B Hale

ADDRESS 115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

D11051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11051

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W. Mulberry St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Ghent

(Residence in Baltimore: No. 1317 W. Mulberry St.: 81 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 16, 1836 (Month) (Day) (Year)

7-AGE, 81 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John H. Guyton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jane Ewing

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agness Guyler

(Address) 1317 W. Windsor Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1892 ~~191~~, to Dec 18 1917, that I saw h[illegible] alive on Dec 18 1917, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ~~1~~ yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) 25 yrs. ..... mos. ..... ds.

(Signed) J. D. Schaut M. D.

12-19, 1917. (Address) 211 N. Stamford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec. 21, 1917.

20-UNDERTAKER John O. Mitchell

ADDRESS 1201 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

DL1052 DL1052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 Wilcox ST.; 9 WARD) REGISTERED NO. C 1750

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catman

(Residence in Baltimore: No. 1318 Wilcox St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec (Month) 5 (Day), 1867 (Year)

7-AGE, 50 yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Struckman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Rs, Catman

(Address) 1214 E. Baltimore St.

15-

Filed ....., 191.....

....., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 191 , to Dec 17 191 , that I saw her alive on Dec 13 191 , and that death occurred, on the date stated above, at 12 55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 18, 191 (Address) 1001 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, 12-20-, 1917.

20-UNDERTAKER Robert Brooks & Son. — ADDRESS Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 108 N. Linwood Ave 6 WARD)

REGISTERED No. C 6 + 189

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin F. Jones

(Residence in Baltimore: No. 108 N. Linwood Ave St.; yrs.,, mos. 7 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write the word.*) Single

6-DATE OF BIRTH, Oct. 17, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Co. Md

PARENTS.

10-NAME OF FATHER, Benjamin F. Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Alice C. McElure

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Jones

(Address) 108 N. Linwood Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) H. Colvin Jr. M. D.
(Coroner.)

Dec 20, 1917. (Address) 2 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, Dec. 20, 1917

20-UNDERTAKER H. Sander & Sons

ADDRESS 1710 E Lat St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11051 D11051 gr

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 S Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Facconelli

(Residence in Baltimore: No. 245 S. Robinson St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, February 8, 1891.
(Month) (Day) (Year)

7-AGE, 26 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Antonio Schiavo

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mary V. Josia

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary V. Josia

(Address) 245 S. Robinson st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 19 1917, to Dec 19th 1917, that I saw her alive on Dec 18th 1917, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

.....

.....

Lobar Pneumonia

..... (Duration)....yrs....mos. 2d. ds.

CONTRIBUTORY (Secondary)

Pneumonia (Duration)....yrs....mos. 5 ds.

(Signed) [illegible] M. D.

Dec 19, 1917. (Address) 435 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 21, 1917.

20-UNDERTAKER Wendell Dypsal Son — ADDRESS 37 1 Avon

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11055 64 D11055

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 W. Lafayette Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levin C. Mackall

(Residence in Baltimore: No. 2003 W. Lafayette Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~ Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Mar. 7, 1837 (Month) (Day) (Year)

7-AGE, 80 yrs. 9 mos. 11 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Dr Richard Mackall

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Mary Elizabeth Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Mackall Jones

(Address) 2003 W. Lafayette Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1917, to Dec 18 1917, that I saw h~~im~~ alive on Dec 18 1917, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Levin C. Mackall M. D.

Dec 19, 1917 (Address) 2042 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Christ Church Cemetery DATE OF BURIAL. Dec 20 1917

20-UNDERTAKER Calvert Co Md ADDRESS Robert L Turner 1742 N. Broadway

Owens Station

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11056

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 817 W. North Ave., ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lina Harman,

(Residence in Baltimore: No. 817 W. North Ave., St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female,	White	Widow,

6-DATE OF BIRTH, Jany. (Month) 28th. (Day), 1844 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 10 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, Wolf Abraham,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Hannah Katzenstein,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Harman

(Address) 817 W. North Ave.,

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 19th. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29th 1917, to Dec 19th 1917, that I saw h[illegible] alive on Dec 19th 1917, and that death occurred, on the date stated above, at 12-15 A. m.

The CAUSE OF DEATH* was as follows:

Sclerosis of the Lungs

Italian Nour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 4 yrs. — mos. — ds.

(Signed) Eugene Vaughan M. D.

Dec. 19th, 1917. (Address) 8 So. Monta Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	Dec. 20th, 1917

20-UNDERTAKER	ADDRESS
Hart & Sondheim	1180 W. Lexington

CAUSE OF DEATH in plain terms, so that it may be correctly applied. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D11057

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Court Aprt. ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Spear,

(Residence in Baltimore: No. N.E.Cor. Linden Ave. & Brooks L ne, 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 19th, (Day) 1847. (Year)

7-AGE, 70 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired,
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Shoes,

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, Isaac Spear,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Augusta Bachrach,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Spear,

(Address) Park Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 18th., (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1917, to Dec 18 1917, that I saw h— alive on Dec 18 1917, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. mos. ds.

(Signed) Thos. J. Glenn M. D.

12/18, 191.7. (Address) 1512 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Balto. Hebrew,	Dec. 20th. 191.7
20-UNDERTAKER. Hartogoudheim	ADDRESS 18 N. Mo Eyg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1105S

CERTIFICATE OF DEATH.

D1105S

64

REGISTERED NO. C.....

1-PLACE OF DEATH 3038 Windsor ave

CITY OF BALTIMORE: (No. 3038 Windsor ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Jane McDonough

(Residence in Baltimore: No. 3038 Windsor ave Walbrook St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 11, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER. John Clarke

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Garrett

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas McDonough

(Address) 3038 Windsor Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 1917,
that I saw her alive on Dec 18 1917,
and that death occurred, on the date stated above, at 10.30 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) yrs. mos. 7 ds.

(Signed) C. Wm. Lane M. D.

Dec....., 191.. (Address) 1540 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL. Dec 21 191..

20-UNDERTAKER Chas. F. Lowe & Son ADDRESS 1911 N. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11059 — 170 — D11059

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 W. North ave, ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna C Lewis

(Residence in Baltimore: No. 819 W. North ave St.: 60 yrs., 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 10th (Day) 1857 (Year)

7-AGE, 60 yrs. 5 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Plimy Webster

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Angelina Chappell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary J. Chappell

(Address) 1113 N. Washington st

15-

Filed ....., 191.... B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Dec 18 1917, that I saw h[illegible] alive on Dec 14 1917, and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Myocardial Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebro-Hemorrhage

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) James C. Clark M. D.

Dec 18, 1917 (Address) 1701 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Dec 20, 1917.
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1120 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 D11060

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Lilly Francis

(Residence in Baltimore: No. 1311 E. Lexington St.; 33 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1 (Year)

7-AGE, 33 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Balto Shirt Co.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert Francis

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary E Wood

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Robert Francis

(Address)..1311 E Lexington st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1917, to Dec 18 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
due to adhesions, with
gangrenous bowel

(Duration)..... yrs. ..... mos. 2 wks. ..... ds.

CONTRIBUTORY (Secondary) Cardiac weakness

(Duration)..... yrs. ..... mos. 2 ds.

(Signed)..E. [illegible] M. D.

....., 191... (Address)..Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. 22 ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Dec 21st, 1917.

20-UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21061

Registered No. C 21061

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 111 S. Collington ave St.) (1/92 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Griffson

(Residence in Baltimore: No. 11 S. Collington ave St.: yrs. 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): infant

6 DATE OF BIRTH: Oct. (Month) 12, (Day) 1917 (Year)

7 AGE: yrs. 2 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Mason

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Griffson

13 BIRTHPLACE OF MOTHER (State or country): U. S. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia Griffson

(Address) 111 S. Collington Ave

15.

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 19 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12th. 1917. to. Dec. 19 1917. that I saw her alive on Dec. 18 .1917. and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY): none

(Duration) yrs. mos. ds.

(Signed) Herman Seidel M. D.

Dec. 19. 1917 (Address) 1931 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Evergreen Cem.

DATE OF BURIAL: 12/20 .191 7.

UNDERTAKER: Jack Lewis

ADDRESS: 1411 E Balto.

Spec.—8-24-14—M. & T.—2000 Bks.

511 Washington St

DL1062

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL1062

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 N. Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mathew Welsh

(Residence in Baltimore: No. 909 N. Castle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 12, 1874
(Month) (Day) (Year)

7-AGE, 43 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)

3/4 003

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Welsh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Cathrin Banning

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cathrine Welsh

(Address) 909 N. Castle St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1917, to Dec. 17th 1917, that I saw him alive on Dec. 17th 1917, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Edw. M. Shuford M. D.

Dec. 18, 1917. (Address) 511 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross

DATE OF BURIAL, Dec 20, 1917

20-UNDERTAKER William Cook

ADDRESS 502 N. Eutaw

N.B. Every question should be carefully answered and no blanks left. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

6

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11063

D11063

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Francis ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Ennis

(Residence in Baltimore: No. 2616 Francis St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June 21, 1838
(Month) (Day) (Year)

7-AGE, 79 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 015
(b) General nature of industry, business, or establishment in which employed (or employer)..... Carpenter

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Leran Ennis.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliz Causey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wilmer Ennis

(Address)..... 2616 Francis St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 191 7, to Dec 19 191 7, that I saw h... alive on Dec 19 191 7, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos. 11 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Nephritis (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Dec 19, 191 7 (Address) 112 W. 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Dec 21, 191 7

20-UNDERTAKER	ADDRESS
Wm. Cook	502 E. North Ave

Dr. Richardson - 112 W. 25th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D11061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. 33rd St. ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant

(Residence in Baltimore: No. 504 N. 33rd St

St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, Dec (Month) 18 (Day), 1917 (Year)

7-AGE, ... yrs. ..... mos. 11/2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Freed

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Louise Pfeffer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Freed

(Address) 504 N. 33rd St.

15-

Filed ....., 191....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 18 1917, to Dec 19 1917, that I saw him alive on Dec 19 1917, and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Foramen Ovale not closed (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. 11/2 ds.

(Signed) H. L. Farr M. D.

Dec 19, 1917. (Address) 12 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Freedom Pa DATE OF BURIAL, Dec 20, 1917

20-UNDERTAKER H. S. Marshall ADDRESS 2539 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11065 HEALTH DEPARTMENT—CITY OF BALTIMORE D11065

CERTIFICATE OF DEATH.

18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 E. Preston St. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Hall Lyon

(Residence in Baltimore: No. 101 E. Preston St. St.; 82 yrs., 9 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, March 4, 1835.
(Month) (Day) (Year)

7-AGE, 82 yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Commission Merchant Retired 17 years

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James E. Lyon

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Owen

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel H. Lyon Jr.

(Address) McDonogh P.O. Md.

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19th, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10th 191 7, to Dec 19th 191 7, that I saw h.. alive on Dec. 19th. 191 7, and that death occurred, on the date stated above, at 7:10 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Exhaustion
(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hyp. Fever Heart Failure

(Duration) yrs. mos. One ds.

(Signed) C. A. Smith M. D.

Dec 19, 191 7. (Address) 1005 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Thomas Church Garrison Forest

DATE OF BURIAL, Dec 21st, 1917.

20-UNDERTAKER Henry W. Jenkins & Son Co

ADDRESS McCulloh & Eutaw Sts.

I. C. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, please state

D11066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11066

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 21 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Semmont

(Residence in Baltimore: No. 1243 Sargeant St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1914 (Year)

7-AGE, 3 yrs. 1 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albert Semmont

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Viola Galloway

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Semmont

(Address) 1243 Sargeant St

15-

Filed ....., 191.....

B Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns on body, face & limbs and flames, Degree Clothes caught from Gas Stove

(Duration) yrs. mos. 5 hrs.

CONTRIBUTORY (Secondary) Shock & Edema

Glottis (Duration) yrs. mos. 6 hrs.

(Signed) James M. Taylor M. D. (Coroner.)

Dec 19, 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Franklin Sq. Hos. In the of death yrs. mos. 5 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1243 Sargeant St

Former or usual residence 1243 Sargeant St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cemetery	Dec. 20, 1917
20-UNDERTAKER	ADDRESS
Mrs Mrs Jno. W. Zenfel	501 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D1106?

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D1106?

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Spring Row ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jannie Kessler

(Residence in Baltimore: No. 117 Spring Row St.; 15 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1847 (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1917, to Dec 18 1917, that I saw h er alive on Dec 18 1917, and that death occurred, on the date stated above, at 7½ m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic interstitial nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis - pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) D. A. Nicholson M. D.

Dec 20, 1917 (Address) 1420 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rodef Sholom	....., 191...
20-UNDERTAKER Jacob Lewis	ADDRESS 1411 E Balto

DEC 20 1917 ROBERT E. LEACH Registrar

Burial Permit

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11068 D11068

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.) 2564 Wilkins Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Stauffer

(Residence in Baltimore: No. 2564 Wilkins Ave. St.; ..... yrs., ... mos. ..... ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Dec. (Month) 19 (Day), 17 (Year)

7-AGE, 5 Months. yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Peter Stauffer

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Lucy Rosendale

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Whiteman

(Address) 2564 Wilkens ave

15-

Filed ....., 191.....

Registrar.

DEC 20 1917 ROBERT A. KRAUSE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1917, to Dec 19, 1917, that I saw h[illegible] alive on Dec 19, 1917, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth,

6 Months

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 6 Months in Utero

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Wilson M. D.

12-19, 1917. (Address) 1730 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Dec 20 191.7

20-UNDERTAKER John F. Bell

ADDRESS 1 Pippitt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P 11069

HEALTH DEPARTMENT—CITY OF BALTIMORE

11069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Nat Bank of Balt St. 29 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A Gault.

(Residence in Baltimore: No. Plaza Apartments St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... Dec. (Month) 20 (Day), 1870 (Year)

7-AGE, 47 yrs. 3 mos. 28 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Banker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Ignatius Gault

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Anna Deal

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H C Lloyd

(Address) .....

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 16 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease (

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Continey M. D.
(Coroner.)

Dec 16, 191.. (Address) 9 E Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Louden Park Cem	Dec. 20., 1917
20-UNDERTAKER	**ADDRESS**
Henry W Jenkins Sons Co	McCulloh and Orchard Sts

Spec.—8-24-14—M. & T.—2000 Bks.

D11070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11070

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth Home ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Freeman

(Residence in Baltimore: No. St. Elizabeth's Home St.; 7 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	negro	Single

6-DATE OF BIRTH, July 8, 1910
(Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Newport News

PARENTS.

10-NAME OF FATHER, Elbert Freeman

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Priscilla Freeman

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Mildred

(Address) St Elizabeths Home

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 15 1917, to December 17 1917, that I saw h.r alive on December 17 1917, and that death occurred, on the date stated above, at 7.4 m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculosis

..... (Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs.....mos.....ds.

(Signed) Frank L Cook M. D.

Dec 19, 1917. (Address) 1327 E Fremont St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	Dec 20, 1917
20-UNDERTAKER George H. Holland	ADDRESS Belmont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D11071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11071

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Harlem Ave St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Carter

(Residence in Baltimore: No. 1110 Harlem Ave St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE,~~ ~~MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, December 10th, 1844 (Month) (Day) (Year)

7-AGE, 73 yrs. 1 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) Baltimore Co., Md

PARENTS.

10-NAME OF FATHER, John Murray

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Englehart M.D.

(Address) 2 N Carrollton Ave

15- ROBERT B. KRAUSE

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19th, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7th 191 7, to Dec. 19th 191 7, that I saw h[illegible] alive on Dec. 9th 191 7, and that death occurred, on the date stated above, at 2:30 d. m.

The CAUSE OF DEATH* was as follows:

Chronic Poisoning

(Chronic Interstitial Nephritis)

..... (Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

..... (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Edward Englehart M. D.

Dec. 19th, 191 7. (Address) 2 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Dec. 21, 1917

20-UNDERTAKER Geo J Smith

ADDRESS 1008 Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11072 ✓ D11072

CERTIFICATE OF DEATH.

+ 20

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wright

(Residence in Baltimore: No. 720 E 8th St Sparrows Point St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Married

6-DATE OF BIRTH, April ....., 1887.
(Month) (Day) (Year)

7-AGE, 30 yrs. 8 mos. 5 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Pvt. 844

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Jack Jennings

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Martha Ward.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.... S. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 191 7, to Dec 18 191 7, that I saw h[er] alive on Dec 18 191 7, and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Septicaemia

.....

.....

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) S. E. Howard M. D.

Dec 18, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 720 E 8th St Sparrows Point

PLACE OF BURIAL OR REMOVAL, Crew Va. DATE OF BURIAL, DEC 21, 191 7

20-UNDERTAKER Sam'l W. Chase & Son ADDRESS 1400 Mosher

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11078

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D11078

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Morling Ave. St.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Gladfelter

(Residence in Baltimore: No. 1303 Morling Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. (Month) 4 (Day), 1842 (Year)

7-AGE, 75 yrs. 1 mos. 15 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

X

037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo. H. Mudd

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Cook

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Gladfelter

(Address) 1303 Morling Ave.

15-

Filed ....., 191.....

Registrar.

DEC 20 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 19 1917, that I saw h[illegible] alive on Dec 18 1917, and that death occurred, on the date stated above, at 5-30 A.m.

The CAUSE OF DEATH* was as follows:

.....

Apoplexy Hemorrhage

Arteriosclerosis Degeneration

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

..... (Duration) 1 yrs. 6 mos. 1 ds.

(Signed) ..... M. D.

Dec 20, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec. 21, 1917

20-UNDERTAKER Horace Dungee & Son

ADDRESS 3631 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11071

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 Huntingdon Ave ST.; W WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis R. Yeiser

(Residence in Baltimore: No. 2820 Huntingdon Ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, March 5, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 9 mos. 13 ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, William F. Yeiser

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Edna M. Gates

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna M. Yeiser

(Address) 2820 Huntingdon Ave

15-

Filed ..., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1917, to Dec 18 1917, that I saw h... alive on Dec 18th 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ... yrs. ... mos. 29 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) ... yrs. ... mos. 3 ds.

(Signed) R. B. Nonnenmacher M. D.

12.19., 191.7 (Address) 354 Chestnut St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
Woodlawn Cem	
20-UNDERTAKER Dunnock Bros	ADDRESS 1617 Eutaw Pl

DEC 20 1917 NOV 21 R. REGISTER

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DL1075

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 DL1075

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 625 W. Baltimore St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Gentile

(Residence in Baltimore: No. 625 W Baltimore St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothes Presser 080
(b) General nature of industry, business, or establishment in which employed (or employer): 487

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Patrick Gentile

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Mary Theresa

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Gentile

(Address) 759 Saratoga St.

15-

Filed....., 191.....

Registrar.

DEC 20 1917

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., December 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I (illuminating Gas Poison (accidental)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Doucett M. D. (Coroner.)

Dec 18, 1917. (Address) 1211 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Redeemer Cemetery	Dec 20, 1917
20-UNDERTAKER	**ADDRESS**
George J. Ruth	1735 Hayford ave.

D11076

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 D11076

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 944 N Durham ST. 1 WARD)

2 FULL NAME Josephene Edna Kuehner

(Residence in Baltimore: No. Same Bath No 944 N Durham

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: 17 October (Month) (Day), 1917 (Year)

7 AGE: ..... yrs. 2 mos. 1 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 1 000

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Adolph Kuehner

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Anna Rybak

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Kuehner
(Address) 944 N. Durham

15 Filed DEC 20 1917, 191 ROBERT L. KRAUSS Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 18th (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1917, to Dec 18 1917.
that I saw h Cr alive on Dec 18 5 PM, 191 .
and that death occurred, on the date stated above, at 11.30 P m.
The CAUSE OF DEATH* was as follows:

Cranston and Marasmus
since birth

(Duration) yrs. mos. ds

Contributory (SECONDARY) acute Bronchitis

(Duration) yrs. mos. ds.

(Signed) Thomas J Dennis M. D.
19, 1917 (Address) 1025 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Schwartze | DATE OF BURIAL: Dec 20, 1917

20 UNDERTAKER: Zickler & Zickler | ADDRESS 1734 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 1107

D 11107

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1370 N. North Ave St.: 43 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Daniel F. Shure

(Residence in Baltimore: No. 1370 N North Ave St.: yrs. 27 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) married

6-DATE OF BIRTH. Dec 2 (Month), 1850 (Day) (Year)

7-AGE, 67 yrs. X mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Carpenter, (b) General nature of industry, business, or establishment in which employed (or employer). 015

9-BIRTHPLACE, (State or Country), Harford Co Md

PARENTS.

10-NAME OF FATHER, Daniel F Shure

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Pa

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Washington Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie M. Shure

(Address) 1370 N North Ave

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry) thereon and from the evidence obtained by said Inquest (autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas Poisoning

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Thomson M. D. (Coroner)

Dec 19 1917 (Address) 3632 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Dec 21, 1917

20-UNDERTAKER Mrs A Rohde Son

ADDRESS 730 Pennsylvania Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DL1078

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

DL1078

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 631 Vine St.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Randolph Shipley

(Residence in Baltimore: No. 631 Vine St.: yrs. 14 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Black	Single

6-DATE OF BIRTH ..... (Month) ..... (Day) , 1903 (Year)

7-AGE 14 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto md

PARENTS

10-NAME OF FATHER: Hesekiah Shipley

11-BIRTHPLACE OF FATHER (State or country): md

12-MAIDEN NAME OF MOTHER: Katie ~~Hobbs~~ Brown

13-BIRTHPLACE OF MOTHER (State or country): md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Shipley

(Address) 631 Vine st

15. .....

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec (Month) 17 th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1917, to Dec 17 1917, that I saw h~~im~~ alive on Dec 17 th, 1917, and that death occurred, on the date stated above, at 350 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) ?

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Ken Williams M. D.

12-18-17 (Address) 91 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Dec 20th, 1917

20-UNDERTAKER: Joseph A Farrell

ADDRESS: 2317 Division st

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11079

CERTIFICATE OF DEATH.

47 D11079

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE (No. Franklin Square Hospital 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Turpin

(Residence in Baltimore: No. 1014 Vine St

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, about 37 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore at
(b) General nature of industry, business, or establishment in which employed (or employer). Lumber Yard 074

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harris

(Address) 1014 Vine St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 17, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Lungs
+ prob. Rheumatic Heart
Sudden
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) James M. Reuben M. D.
(Coroner.)

Dec 20 191 7 (Address) 700 E. Clare St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec. 20, 1917

20-UNDERTAKER Jos. H. Dennis ADDRESS 130 Byrd Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11080

CERTIFICATE OF DEATH.

28 D11080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 East Lynn St.: 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J Fleetwood

(Residence in Baltimore: No. 411 East Lynn St.: 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, Sept 23, 1854 (Month) (Day) (Year)

7-AGE, 33 yrs. 2 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Isaac Jones

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Owens

(Address) 411 East Lynn St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917, to Dec 19 1917, that I saw her alive on December 18 1917, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. mos. 14 ds.

(Signed) Asa L Wessels M. D.

Dec 20, 1917. (Address) 2565 Frederick Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 21, 1917.

20-UNDERTAKER Geo. E. Schwab & Bro

ADDRESS 2101 Frederick Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11081

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040. Fountin ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna. Golas

(Residence in Baltimore: No. 2040 Fountin St.; ..... yrs., 7 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, April 28, 1917
(Month) (Day) (Year)

7-AGE. ..... yrs. 7 mos. 21 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... " " 000

9-BIRTHPLACE, (State or Country). Baltmore

PARENTS.

10-NAME OF FATHER. Alex. Golas

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna Kulis

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alex Golas

(Address) 2040 Fountin

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1917, to Dec. 19 1917, that I saw her alive on Dec. 18 1917, and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Catarrh
accompanied by Bronchitis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Rehberger M. D.

Dec 19, 1917. (Address) 1709 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Dec. 20, 1917.

20-UNDERTAKER Wm Fiallowsk

ADDRESS 1618 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1082 D1082

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3334 Smallwood ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J McGinnis

(Residence in Baltimore: No. 3334 Smallwood St.; 80 yrs., 10 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. February 10th, 1837
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
80 yrs. 10 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— 000
(b) General nature of industry, business, or establishment in which employed (or employer) ——— 000

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, James Jones

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER, Mary Jane Short

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F Gannon Son

(Address) 3333 Smallwood

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 18th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th 1917, to Dec 18th 1917, that I saw h[er] alive on Dec 17th 1917, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

General Debility about

(Duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY (Secondary) Weakness

(Duration) ...yrs. ...mos. ...ds.

(Signed) Benj Dorsey M. D.

12/19, 191.7 (Address) 400 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Dec 20, 191.7

20-UNDERTAKER F B Shipley — ADDRESS 1734 Fleet Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11083

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 W Fairmount Ave. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Roberts

(Residence in Baltimore: No. 2506 W. Fairmount Ave. St.; 66 yrs., 7 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) Apr. 20 (Day), 1851 (Year)

7-AGE: 66 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired.
(b) General nature of industry, business, or establishment in which employed (or employer): ood

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Samuel Roberts

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Sarah Bigh

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. Roberts

(Address) 2506 W. Fairmount Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from (Dec) 4, 191 to Dec 19 1917, that I saw h[illegible] alive on Dec 18 1917, and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Roscoe Krause M. D.

Dec. 19, 1917. (Address) 243 Huntingdon Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec 22, 1917.

20-UNDERTAKER: F. B. Kephart

ADDRESS 1336 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11081

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Ensor ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Moller

(Residence in Baltimore: No. 1013 Ensor St.; 57 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 20, 1838
(Month) (Day) (Year)

7-AGE, 79 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired 080
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Tailor

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bernadina Moller

(Address) 1013 Ensor St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1914, to December 20, 1917, that I saw him alive on " 19 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Probably 3 years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Tuttman M. D.

Dec. 20, 1917. (Address) 1121 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Dec. 22, 1917.

20-UNDERTAKER Henry Stoeckel Son

ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 20 1917

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11085 Taylor D11085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 659 Bradley ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Taylor

(Residence in Baltimore: No. 659 Bradley St St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown (Month) 1 (Day) 185 (Year)

7-AGE, 32 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Peter Moss

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S Spencer Taylor

(Address) 659 Bradley St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia Bronchial
2. Acute Heart D
3. (Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) yrs. mos. 10 ds.

(Signed) L D Gittings Brainard M. D.

Dec 19, 1917. (Address) 709 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rose Dawn Louisville Va

DATE OF BURIAL, Dec 20 1917

20-UNDERTAKER Jno H Holland

ADDRESS 1631 Druid Hill

D11086

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

15 D11086

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1729 Thomas ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard C Glenn

(Residence in Baltimore: No. 1729 Thomas St.; yrs. 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: 9 (Month) 11 (Day) 1917 (Year)

7-AGE: ..... yrs. 3 mos. 22 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Curtis Glenn

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Dora Schlunn

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dora Glenn

(Address) 1729 Thomas Ave

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-10, 1917, to, 12-19 1917, that I saw him alive on 12-18 1917, and that death occurred, on the date stated above, at 10½ a. m.

The CAUSE OF DEATH* was as follows:

Marasmus. 000

(Duration) ..... yrs 1½ mos. ..... ds.

Contributory (SECONDARY): Exhaustion

(Duration) ..... yrs ..... mos. ..... ds.

(Signed), A. R. Cullum M. D.

12-19, 1917 [Address] 2757 Monroe

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 20 1917

20-UNDERTAKER: Harry D. Wiltz Co — ADDRESS: 1531 W. Lombard St.

Spec.—8-24-14—M. & T.—2000 Bks.

D1087 D1087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Brice ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Laird Howard

(Residence in Baltimore: No. 604 Brice St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH: October (Month) 4th (Day), 1860 (Year)

7-AGE: 57 yrs. 2 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Findlay

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Annie McDowell

13-BIRTHPLACE OF MOTHER (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. T. Smith

(Address) Athens Ga.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1917, to Dec. 19 1917, that I saw her alive on Dec 19 1917, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Due to operation)

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Ulcer of Stomach

(Duration) ..... yrs. ..... mos. 1 yr ds.

(Signed) Paul Brown M. D.

Dec. 19, 1917. (Address) 1837 Pinna Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Dec 22 1917.

20-UNDERTAKER Chenoweth & Son. ADDRESS 3619 Chestnut Ave.

DEC 20 1917 ROBERT P. KING Registrar of Vital Statistics

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11088

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Costello

(Residence in Baltimore: No. 903 Cathedral St St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 12, 1857 (Month) (Day) (Year)

7-AGE, 60 yrs. 7 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Maid
(b) General nature of industry, business, or establishment in which employed (or employer)..... 870

8 M

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph Costello

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary McNamara

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1917 to Dec 18 1917, that I saw h[illegible] alive on Dec 18 1917, and that death occurred, on the date stated above, at 6.35 p.m.

The CAUSE OF DEATH* was as follows:

Primary Anemia

.....

.....

..... (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) yrs. mos. 3 ds.

(Signed) S. E. Howard M. D.

Dec 19 1917 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 903 Cathedral St

19-PLACE OF BURIAL OR REMOVAL [illegible] Cathedral Cem. DATE OF BURIAL, Dec 20 1917

20-UNDERTAKER John F. Fahey & Bro ADDRESS 1318 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103

D11089

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 844 ~~E. Sharp~~ E. Eutaw St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Green

(Residence in Baltimore: No. 844 ~~E. Sharp~~ E. Eutaw St.; 27 yrs., ... mos. ..... ds.)

J. Grey Bowley

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... Feb. (Month) ..... 1 (Day), 1890 (Year)

7-AGE, ... 27 yrs. ..... 10 mos. ..... 17 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Ohio

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Chas Green

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Hattie Ferguson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Green

(Address) 844 E. Eutaw

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 18th (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17th 1917, to Dec. 18th 1917, that I saw him alive on Dec. 18th 1917, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart due to Acute Gastritis (Indigestion)

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Grey Bowley M. D.

12/20/1917, 191... (Address) 136 W. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn | DATE OF BURIAL, Dec. 20, 191..

20-UNDERTAKER E. K. Brown & Son | ADDRESS 1100 W. Monty St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

DL1090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

DL1090

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1542 Friendsburg Place ST.; 15 WARD)

2-FULL NAME Edwin Burdett

(Residence in Baltimore: No. 1542 Friendsbury Place St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 21, 1837
(Month) (Day) (Year)

7-AGE, 79 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Draughtsman
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 086

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Aaron Burdett

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rosa Gilbraith

(Address) 1544 Friendsburg Place

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1915, to Dec 19 1917, that I saw him alive on Dec 19 1917, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Epithelioma a Face

Cancer (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) C. Hamilton

(Duration) yrs. mos. ds.

(Signed) J. Thomas Scharf M. D.

Dec 29 1917. (Address) 1001 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Dec 21, 1917.

20-UNDERTAKER Wm. Cook — ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11091

CERTIFICATE OF DEATH.

D11091

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cordova Apts. St.; Lake Drive WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Fisher Juhn

(Residence in Baltimore: No. Cordova apts St.; Lake Drive yrs. Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 5" (Month) (Day), 1916 (Year)

7-AGE, 1 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER Sydney L. Juhn

11-BIRTHPLACE OF FATHER (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Beatrice Fisher

13-BIRTHPLACE OF MOTHER (State or Country) Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sydney L. Juhn

(Address) Cordova Apts.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 19" (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 8 191 7, to Dec 19 191 7, that I saw her alive on Dec 19 191 7, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Pyogenes

..... (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

..... (Duration) yrs. mos. 2 ds.

(Signed) Wm Mulvihill M. D.

Dec 20, 191 7. (Address) 11 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oheb Sholom Cem DATE OF BURIAL, 12/24, 191 7

20-UNDERTAKER David Londheim ADDRESS 1180 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11092

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Jelinek

(Residence in Baltimore: No. 2025 Orleans St.; 55 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct 31st (Month) (Day), 1841 (Year)

7-AGE, 76 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton Rytina

(Address) 3717 Springdale Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 19 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

(Signed) Edward J. Cook M. D.

12/19, 1917. (Address) 413 N Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Hill Cem.	Dec. 21 191..
20-UNDERTAKER	ADDRESS
Philip Henrig	2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11093

CERTIFICATE OF DEATH.

91 D11093

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Lancaster ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genovefa Janicka

(Residence in Baltimore: No. 1604 Lancaster St.; 3 yrs., 9 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Whit

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Sing

6-DATE OF BIRTH, Mar (Month) 14 (Day) 1914 (Year)

7-AGE, 3 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " " 000

9-BIRTHPLACE, (State or Country), Baltemore

PARENTS.

10-NAME OF FATHER, Frank Janicki

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Jozefa Lesnicka

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jozefa Lesnicka

(Address) 1604 Lancaster

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 191 , to Dec 19 191 , that I saw h[illegible] alive on Dec 17 191 , and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

(a) ?
(b) Broncho Pneumonia
(c)
(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 19, 191 (Address) 16 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Dec 21, 191[illegible]

20-UNDERTAKER William Frallsowski — ADDRESS 1618 Eastern Ave

DEC 20 1917 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D11091

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 S. Linwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Kenny

(Residence in Baltimore: No. 641 S Linwood St.; 50 yrs.,.. mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Aug (Month) ..... (Day), 1848 (Year)

7-AGE, 68 yrs. 4 mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... D37

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Conroy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John F. Kenny

(Address)..... 641 S. Linwood ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1917, to Dec 18 1917, that I saw h.. alive on Dec 18 1917, and that death occurred, on the date stated above, at 7.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Tubal Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) yrs. 9 mos. ds.

(Signed) O. L. Long M. D.

....., 191... (Address) 2701 Eutaw a

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Patrick

DATE OF BURIAL, Dec 21 1917

20-UNDERTAKER John A Moran

ADDRESS Bank & Eutaw sts

DEC 20 1917 ROBERT E. KRAUTER DEPUTY REGISTRAR

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of information should be given so that it may be

D11095 HEALTH DEPARTMENT—CITY OF BALTIMORE D11095

CERTIFICATE OF DEATH.

+175

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lawson

(Residence in Baltimore: No. 3 days St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	married

6-DATE OF BIRTH, January 9, 1900
(Month) (Day) (Year)

7-AGE, 17 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O H 3 O

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Stephen Lawson

11-BIRTHPLACE OF FATHER (State or Country), Ga

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hosp

15-

Filed ....., 191.....

B. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis
Left Upper Lobe
Maryville Tennessee

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Smiley M. D.
(Coroner.)

12-20 1917. (Address) Maryville Tenn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Maryville Tenn

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Maryville Tenn	Dec. 20, 1917
20-UNDERTAKER	ADDRESS
Albert E Fuller	321 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL1096 DL1096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mulberry & Cathedral REGISTERED NO. C 143

CITY OF BALTIMORE: (No. Mulberry & Cathedral ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank M Davis

(Residence in Baltimore: No. Stentworth Apts Cathedral & Mulberry St.; 3 yrs., moa. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Sept 21, 1866 (Month) (Day) (Year)

7-AGE, 51 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 65 66
(a) Trade, profession, or particular kind of work: Sales Manager
(b) General nature of industry, business, or establishment in which employed (or employer): C O Pruden Co.

9-BIRTHPLACE, (State or Country), Lisbon N.Y.

PARENTS.

10-NAME OF FATHER, Mason L. Davis

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Lucina Armstrong

13-BIRTHPLACE OF MOTHER (State or Country), Lisbon N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lucina Davis

(Address) Stentworth Apts

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5th 1917, to Dec 19, 1917, that I saw h alive on Dec 19 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Blood poisoning, Tuberculosis Carbuncle

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carbuncle

(Duration) yrs. mos. ds.

(Signed) N. K. Gorsuch M. D.

Dec 19, 1917. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Dec 21, 1917.

20-UNDERTAKER Jos B Clark — ADDRESS 1003 W Baltimore St

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11097

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 W. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Nichols

(Residence in Baltimore: No. 846 W. Lexington St. St.; 56 yrs., 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, June 6, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. 6 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Faddoul M.D.

(Address) 117 N. Carrollton Ave.

15-

Filed....., 191.....

Registrar.

B.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1917, to June 18 1917, that I saw her alive on June 18 1917, and that death occurred, on the date stated above, at 1050 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Faddoul M. D.

June 18, 1917. (Address) 117 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Dec 21, 191.
20-UNDERTAKER	**ADDRESS**
Jos B Cook	1033 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1098 — 30 — 1098

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 W. Mulberry ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Bernard Shield

(Residence in Baltimore: No. 1106 W. Mulberry St.; 7 yrs., 8 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 17, 1909
(Month) (Day) (Year)

7-AGE, 7 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, J. B. Shield.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Annie Davis

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Davis

(Address) 1106 W. Mulberry

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 18 1917, that I saw h-- alive on Dec 17 1917, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Instant Pneumonia

Contributory Hypertrophy Myocard.

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) t. D.

(Duration) yrs. mos. ds.

(Signed) t. M. Lawrence M. D.

12/18, 1917. (Address) 201 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec. 21st, 191..
20-UNDERTAKER	ADDRESS
H. J. Poelmeyer	Reno Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 11099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 11099

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Dallas St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus Priddle

(Residence in Baltimore: No. 405 N. Dallas St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, a. a

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) ..... (Day) 1 (Year)

7-AGE, 19 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

8 17

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Priddle

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Priddle

(Address) 405 N. Dallas St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 18, ..., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1917, to Dec. 18 1917, that I saw her alive on Dec. 17, 1917, and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

Pulmonis Pulmonalis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchiectasis

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. R. Bivins M. D.

Dec. 19, 1917 (Address) 1520 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, DEC 21 1917

20-UNDERTAKER H. C. Gross — ADDRESS 745 McCulloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

DL1100

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL1100

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2746 W. Lafayette ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Faubare

(Residence in Baltimore: No. 2746 W. Lafayette St.; — yrs., 11 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 2, 1917
(Month) (Day) (Year)

7-AGE, — yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): 800 800

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Paul Faubare

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Maria A. Faubare

(Address) 2746 W. Lafayette ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1917, to Dec 19 1917, that I saw him alive on Dec 19 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Measles.

(Duration) ....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebro-spinal "Spinal Meningitis"

(Duration) ....yrs.....mos.....ds.

(Signed) J. T. Grace M. D.

Dec 19, 1917. (Address) 804 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Dec 20, 191.7.
20-UNDERTAKER	ADDRESS
Martin Father & Sons	606 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

011101 011101

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1934 W. Franklin ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert A. Cunningham

(Residence in Baltimore: No. 1934 W. Franklin St.; 52 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 23, 1843 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
74 yrs. 6 mos. 26 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country), Harford Co. Md

PARENTS.

10-NAME OF FATHER, Edgar Cunningham

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md

12-MAIDEN NAME OF MOTHER, Elizabeth Hollingsworth

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Little

(Address) 531 N. Fremont Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 191 7, to Dec 19 191 7, that I saw h[illegible] alive on Dec 19 191 7, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis Arterio Sclerosis

(Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) H. E. Pleasants M. D.

Dec 20, 191... (Address) 1600 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Fallston Md	Dec. 27, 1917.
20-UNDERTAKER	ADDRESS
Geo W Little	531 N. Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11102

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D11102

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 610 W. Barre ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel A Davey.

(Residence in Baltimore: No. 610 W. Barre St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1833 (Year)

7-AGE, 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) work.

9-BIRTHPLACE, (State or Country) Washington D. C.

PARENTS.

10-NAME OF FATHER John Schneider

11-BIRTHPLACE OF FATHER (State or Country) Washington D C

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Weller

(Address) 610 W Barre St

15-

Filed ....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 12 1917, that I saw h[illegible] alive on Dec. 12 1917, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

(a) [illegible]

(b) Cerebral Hemorrhage

(c) ..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 19 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem DATE OF BURIAL, Dec 20, 1917.

20-UNDERTAKER John Flanagan & Son ADDRESS 701 Hollins St

P. S. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D1103 104 D1103

1 PLACE OF DEATH Robert Garrett Hospital 70 REGISTERED No. C.....

CITY OF BALTIMORE: (No. 27 N Leavy ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Gillard

(Residence in Baltimore: No. 2113 Wilkens ave St.; 5 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 4 (Month) (Day), 1917 (Year)

7-AGE: ..... yrs. 3 mos. 16 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Arthur H Gillard

11-BIRTHPLACE OF FATHER (State or country): Howard Co Md

12-MAIDEN NAME OF MOTHER: Mamie C Blackwell

13-BIRTHPLACE OF MOTHER (State or country): Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur H Gillard

(Address) 2113 Wilkens ave

15-

Filed ....., 191 .....

B. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 20 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 17, 1917, to, December 20 1917, that I saw h.r alive on December 19 1917, and that death occurred, on the date stated above, at 9 Eo a. m.

The CAUSE OF DEATH* was as follows:

Pleo colitis

(Duration) ..... yrs 2 mos. 7 ds.

Contributory (SECONDARY): Malnutrition

(Duration) ..... yrs 3 mos. 6 ds.

*(Signed), Theodore Cook M. D.

Dec 20 1917 [Address] 27 Leavy St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos. 3 ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Grove Cem Howard Co Md

DATE OF BURIAL: Dec 21 1917

20-UNDERTAKER: Leo A Gerty

ADDRESS: Balto & Payson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

P1101 92 P1101

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Brent ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Cromwell

(Residence in Baltimore: No. 2225 Brent St ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) ——

6-DATE OF BIRTH, Dec 19, 1914
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Marshall Cromwell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lizie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Cromwell

(Address) 2225 Brent St

15-

Filed ....., 191.....

..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/16 1917, to 12/20 1917, that I saw h[illegible] alive on 12/19 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 21 1917 (Address) 713 S. Eden St Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N Bway

N.B. Every item of information given must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1105 D1105

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Spahn

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, December 2, 1917.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Balto; Md

PARENTS.

10-NAME OF FATHER, Fredrick Myers

11-BIRTHPLACE OF FATHER (State or Country). Balto; Md.

12-MAIDEN NAME OF MOTHER Marie Spahn

13-BIRTHPLACE OF MOTHER (State or Country), Balto; Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. J. Roberts M.D.

(Address).... Md. General Hospital

15- 0 17

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 17 1917, that I saw her alive on Dec 17 1917, and that death occurred, on the date stated above, at 10P. m.

The CAUSE OF DEATH* was as follows:

..... (a) Malnutrition .....

.....

..... (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) ..... Prematurity .....

..... (Duration)....yrs....mos....ds.

(Signed)..... J. E. Roberts ..... M. D.

....., 191... (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. 15 ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL. ....., 191...
20-UNDERTAKER	ADDRESS

DEC 20 1917 ROBERT N. KRAUTER Commissioner Health

15385

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD) REGISTERED No. C 151

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hartman

(Residence in Baltimore: No. Womans Hospital St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, Dec 20, 1917. (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 5 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Lee Emanuel Hartman

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Carlyn Friedman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) Womans Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 20 1917, that I saw her alive on Dec 20 1917, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Premature
Placenta Praevia
....
.... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....
.... (Duration) ....yrs....mos....ds.

(Signed) M L Cole M. D.

....., 191... (Address) 536 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? Womans Hosp.

Former or usual residence Womans Hosp.

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem. DATE OF BURIAL, 12/20/17

20-UNDERTAKER D Sondheim & Co ADDRESS 811 W Mt Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womans Hospital 151 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hartman

(Residence in Baltimore: No. Womans Hospital St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH Dec 20, 1917. (Month) (Day) (Year)

7-AGE, 0 yrs. mos. ds.

If LESS than 1 day, 0 hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE. (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Lee Emanuel Hartman

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Carolyn Friedman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Rinaldi

(Address) Womans Hospital

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 20 1917, that I saw him alive on Dec 20 1917, and that death occurred, on the date stated above, at 6.7A m.

The CAUSE OF DEATH* was as follows:

Pneumo-enteritis,
Placenta Praevia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

....., 191... (Address) 56 W Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 min ds. State ..... yrs. 5 mos. ds.

Where was disease contracted, if not at place of death? Womans Hosp.

Former or usual residence Womans Hosp

19-PLACE OF BURIAL OR REMOVAL, Bals Hebrew Cem DATE OF BURIAL, 12/22, 191..

20-UNDERTAKER L Sondheim ADDRESS 1180 W Mt Royal Ave

DEC 20 1917 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1110S

CERTIFICATE OF DEATH.

91

D1110S

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N Wolfe ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Therese Gl Metzger

(Residence in Baltimore: No. 415 N Wolfe St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (Write the word.) Widow

6-DATE OF BIRTH, Sept (Month) 14 (Day) 1833 (Year)

7-AGE, 82 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Fredk Bolster

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Hartman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ada Metzger

(Address) 415 N Wolfe St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 18 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191 7, to Dec 18 191 7, that I saw h e alive on Dec 18 191 7, and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

..... (Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Senile Debility

..... (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 19, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State ..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Dec 21, 1917.

20-UNDERTAKER J Ferris & Co

ADDRESS 2008 Aliceanna

DEC 21 1917 ROBERT R. CRAUTER

N. B. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

11109

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

11109

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Madison Ave; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. John Charles Wilson M.D.D.S.

(Residence in Baltimore: No. 938 Madison Ave St.; 71 yrs., 9 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED OR DIVORCED, (WHICH THE WORD)~~ Single

6-DATE OF BIRTH, March 17, 1846 (Month) (Day) (Year)

7-AGE, 71 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dentistry
(b) General nature of industry, business, or establishment in which employed (or employer)..... 056

9-BIRTHPLACE, (State or Country), Balto. Maryland

PARENTS.

10-NAME OF FATHER, Erasmus R.

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Deady.

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara Wilson

(Address) 938 Madison Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 1917, to Dec 19 1917, that I saw him alive on Dec 19 1917, and that death occurred, on the date stated above, at 10.05 m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno. H. Wilson M. D.

Dec 20, 1917 (Address) 1025 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, 12-22-, 1917

20-UNDERTAKER Henry W. Jenkins & Sons

ADDRESS Howard & McCulloh Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

DEC 21 1917 ROBERT R. STRAUSS

D1110

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D1110

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1207 W. Lanvale ST.: 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine M Courtney

(Residence in Baltimore: No. 1207 W. Lanvale St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept (Month) , 1842 (Year)

7 AGE: 75 yrs. 3 mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): — Va —

PARENTS

10 NAME OF FATHER: Alexander Courtney

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Lane

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Robt A. Courtney

(Address) 1207 W. Lanvale St

15 DEC 21 1917 ROBERT B. KRAUTER

Filed . 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 20 (Day) , 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 , 1917 , to Dec 20 1917 , that I saw her alive on Dec 19 , 1917 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
+ Emphysema
Some

(Duration) 15 yrs. mos. ds

Contributory (SECONDARY): Asthenia + Gen Ex Exhaustion for last 2 months

(Duration) yrs. mos. ds.

(Signed) Dr Robert F Mufflin M. D.

Dec 20 , 1917 (Address) 1016 Mad St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral | DATE OF BURIAL: Dec 22 1917

20 UNDERTAKER: H. M. Gaulbert | ADDRESS: 624 - N Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Cumberland St. 15 WARD)

2-FULL NAME Mrs Alice R. Dodd

(Residence in Baltimore: No. 716 Cumberland St.; 40 yrs. mos. ds.)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fem

4-COLOR OR RACE: Wht

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Mch 30, 1857 (Month) (Day) (Year)

7-AGE: 60 yrs. 8 mos. 18 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 048

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Mr. L. Reese

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Jane E. Barker

13-BIRTHPLACE OF MOTHER (State or country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nellie Price

(Address) 716 Cumberland St

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. 18th, 191 7 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 191 7, to Dec 18 191 7, that I saw h alive on Dec 18 191 7, and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonis Following
Influenza, Mitral Insufficiency
Pneumonia

(Duration) yrs 6 mos ds.

Contributory (SECONDARY): Dropsy, Failing Heart

(Duration) yrs 2 mos ds.

(Signed) E. Blount M. D.

Dec 19, 191 7 [Address] 1605 W North Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mount Auburn

DATE OF BURIAL: Dec 22, 191 7

20-UNDERTAKER: J. M. Gunther

ADDRESS: 1624 W

J Howard-

Repd. Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1112 — 64 — D1112

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2436 Etting ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie E Smith

(Residence in Baltimore: No. 2436 Etting St. St.; 40 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nat unc, 1 (Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 00
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Amherst Co Va.

PARENTS.

10-NAME OF FATHER, Edith Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nat unc

13-BIRTHPLACE OF MOTHER (State or Country), Nat unc

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bettie Johnson

(Address) 2436 Ettings St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/11 1917, to 12/19 1917, that I saw h[illegible] alive on 12/18 1917, and that death occurred, on the date stated above, at 6:40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) B. M. Chesser M. D.

12/21, 191[illegible] (Address) 2173 Druid Park Dr.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, DEC 21 1917, 191...

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1113 D1113

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 18 Ward)

REGISTERED NO. C 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby allport

(Residence in Baltimore: No. 837 Hollins St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, November 16, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Lucy Compton

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lucy Allport

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Shumway Jr

(Address) Hosp

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 15, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1917, to Dec 15 1917, that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Suppurative Meningitis

(Duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary) Septicemia & Shock

Dysentery (Duration) ....yrs. ....mos. 4 ds.

(Signed) John Shumway Jr M. D.

Dec 19 1917. (Address) Johns Hopkins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. ....ds. In the State ....yrs. 1 mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 837 Hollins

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL DEC 19 1917
DEC 21 1917 ROBERT B. KRAUTER
Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D1111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 1120

CITY OF BALTIMORE: (No. 706 S. Port ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Bangert

(Residence in Baltimore: No. 706 S. Port St.; 52 yrs., 11 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec. 24th (Month) (Day), 1865 (Year)

7-AGE, 52 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework at
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Marcus Rilgert

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Louisa Eullina

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Manning

(Address) 706 S. Port St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 20th (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec. 20 1917, and that death occurred, on the date stated above, at 12.50 m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebral Nephritis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) ... yrs. 1 mos. ... ds.

(Signed) C. Lentz M. D.

12/20, 191 7. (Address) 2701 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Dec. 24th, 1917

20-UNDERTAKER Lilly-Zeiler

ADDRESS 403 S. Wolfe St.

DEC 21 1917 ROBERT N. GRAMMER DEPUTY REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11115 79 ✓ D11115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1923 Gough ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Pettenkofer.

(Residence in Baltimore: No. 1923 Gough St.; 59 yrs., 7 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 4th, 1858
(Month) (Day) (Year)

7-AGE, 59 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Max Pettenkofer.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Kinzer

(Address) 1923 Gough St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21st, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 20 1917, that I saw h*im* alive on Dec 20 1917, and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Duodenal Hemorrhage

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) 1 yrs. mos. ds.

(Signed) J. H. Buxton M. D.

Dec. 21, 1917. (Address) 1125 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec. 24, 1917.

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 N. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C 92

CITY OF BALTIMORE: (No. 3713 Springdale Ave St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Albaugh

(Residence in Baltimore: No. 3713 Springdale Ave St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Autumn 1 (Month) (Day) (Year)

7-AGE: 40 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Wm. A. Botzfitz

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Sarah Holbrook

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm A Albaugh
(Address) 3713 Springdale

15-
Filed ....., 191 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29, 1917, to, Dec 19 1917, that I saw her alive on Dec 19 1917, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs mos 21 ds

Contributory (SECONDARY): Myocarditis

(Duration) yrs mos 21 ds.

(Signed) Carlton R Peacock M. D.

Dec 20, 1917 [Address] 2806 Garrison Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 21, 1917

20-UNDERTAKER: Wm J Lickner — ADDRESS: Lon. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wade

(Residence in Baltimore: No. 1039 E Howard St St.; yrs., mos. ds.)

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, ..., 1876.
(Month) (Day) (Year)

7-AGE, 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER. William Riley

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Wisi

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Abbott

(Address) 411 W Hamburg St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 21 1917, that I saw h er alive on Dec 21 1917, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Paresis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry M Ellis M. D.

Dec 24, 1917 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 1039 E Howard St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 24, 1917.

20-UNDERTAKER J. L. Brountson — ADDRESS 108 North Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

Mamie Clayton.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1118 91 D1118

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 942 Lanvale St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Clayton

(Residence in Baltimore: No. 942 Lanvale St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	married

6-DATE OF BIRTH, June 26, 1877
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ....mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. White

(Address) 942 Lanvale St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1917, to Dec 20 1917, that I saw h[illegible] alive on Dec 9 1917, and that death occurred, on the date stated above, at 4[illegible] m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Dec. 22, 1917
20-UNDERTAKER	ADDRESS
J. L. Blountson	108 Mon[illegible] St

Spec.—8-24-14—M. & T.—2000 Bks.

DL1119

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL1119

CERTIFICATE OF DEATH.

96 ✓

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 E 22nd ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar F Swift-

(Residence in Baltimore: No. 436 E 22nd St.)

(If not in Baltimore, give usual residence.)

(Length of residence in Baltimore.....yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 14, (Month) ..... (Day), 1896 (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 2 mos. 6 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Luke Swift

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Jane Heath

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jane Swift

(Address) 436 E. 22nd St

15-

Filed....., 191.....

Registrar.

DEC 21 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, (Month) ..... (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3d, 1917, to Dec 20th, 1917, that I saw him alive on Dec 19th, 1917, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

"Acute Mediastinitis, Acute Secondary Infection, Acute Remaining Empyema, Hemorrhage in Pleural Cavity"

Gonorrhea (Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Septicaemia, ...

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Wilmer Brinton, M. D.

Dec 21st, 1917 (Address) Colonial Apartments

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 22, 191

20-UNDERTAKER	ADDRESS
Robert F Gunn	1422 Bank Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

211120

HEALTH DEPARTMENT—CITY OF BALTIMORE

211120

CERTIFICATE OF DEATH.

79v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 W Lexington ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Kepfler

(Residence in Baltimore: No. 1526 W Lexington St.; 67 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Widower

6-DATE OF BIRTH, April 16 (Month) (Day), 1830 (Year)

7-AGE, 87 yrs. 8 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

467 080

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Burkeart Kepfler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Kepfler

(Address) 1739 W Lanvale St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1916 191..., to [illegible] 1917, that I saw h[illegible] alive on [illegible] 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

my 0 Cardiac
Result of Hemoplegia
Senile

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemoplegia Jan 7 1916

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Cagan M. D.

Dec 20 1917. (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec 22, 1917

20-UNDERTAKER, Robert F Burns

ADDRESS 942 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

11121 — 28 — 11121

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Found dead Mercy Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Justice also called Percy M. Mullin

(Residence in Baltimore: No. 608 Jasper Mother's residence St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Dec. 1 (Month) (Day) (Year)

7-AGE, about 17 yrs. ..... mos. ..... ds. Under 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dept. Run
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Dept. Run

PARENTS.

10-NAME OF FATHER, James A. Justice

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary E. Richardson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Justice

(Address) 608 Jasper

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fulm. Hemorrhage
Probable Pulm. Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dept. Run
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Tilley (Coroner.) ..... M. D.

Dec 18, 1917. (Address) 162 Dept Run

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Dec. 26, 1917
20-UNDERTAKER Name Gordon	ADDRESS 916 Pa - ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 W Hamburg ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne mary Bauer

(Residence in Baltimore: No. 758 W Hamburg St.: 73 yrs. 3 mos. 10 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. Sept (Month) 9 (Day), 1844 (Year)

7-AGE. 73 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none 000

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Wm H Reisenbuger

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Annie M Reisenbuger

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A Schwarz

(Address) 758 W Hamburg st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1917, to Dec 19 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Apoplexy

..... (Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wm Stoop M. D.

Dec 21, 1917. (Address) 829 Eutaw St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Dec 22, 1917.
20-UNDERTAKER	**ADDRESS**
James Dignan & Son	1000 E. Pratt St

Spec.—8-24-14—M. & T.—2000 Blks.

Boudon.

D1123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1123

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 Abbotson ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Boudon

(Residence in Baltimore: No. 1643. Abbotson st. St.; ....yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 65 years ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): Work.

9-BIRTHPLACE, (State or Country), Belgian

PARENTS.

10-NAME OF FATHER, Joseph Suwan

11-BIRTHPLACE OF FATHER (State or Country), Belgian

12-MAIDEN NAME OF MOTHER Josephine Suwan

13-BIRTHPLACE OF MOTHER (State or Country), Belgian

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Boudon

(Address) 1643 Abbotson st.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 14 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 191 7, to Dec 14 191 7, that I saw h[illegible] alive on Dec 14 191 7, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(Duration) 2 yrs. ....mos. ....ds.

(Signed) J. H. D[illegible] M. D.

Dec 20th, 191 7 (Address) 107 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Dec 22, 191 7

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Harford ave.

DEC 21 1917 — REGISTRAR OF VITAL STATISTICS — BUREAU OF VITAL STATISTICS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 V

D11121

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 E. Federal ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E. Casby

(Residence in Baltimore: No. 1421 E. Federal St.

Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Dec 8th (Month) (Day), 1846 (Year)

7-AGE. 51 Years ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 050 000

(a) Trade, profession, or particular kind of work ..... Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Widow

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andrew Casby.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Logan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mary Lee

(Address) ..... 1421 E. Federal St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1917, to Dec 21 1917, that I saw h[er] alive on Dec 20 191..., and that death occurred, on the date stated above, at 430 m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Embolism

..... Fracture Middle

..... Third Rib (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

Dec 24, 191... (Address) 1059 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Dec 24, 191...

20-UNDERTAKER George F. Roth — ADDRESS 1735 Hayford Ave

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D11125

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosanna Arents

(Residence in Baltimore: No. 30 Huntington Ave St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept. (Month) 17th (Day), 1839 (Year)

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Co Md.

PARENTS.

10-NAME OF FATHER, Martin Woltz.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Grimstead.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret Cooper.

(Address) 333 W 30th St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 191 7, to Dec 21 191 7, that I saw h[er] alive on Dec 20 - 191 7, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
Mitral regurgitation
(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation
(Duration) yrs. mos. 1 ds.

(Signed) Benj. M. Joffe M. D.

Dec 21, 191 7. (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 30 Huntington Ave

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cem Hampden — DATE OF BURIAL, Dec 23rd, 191 7.

20-UNDERTAKER, Henry H. Jenkins & Sons Co — ADDRESS, Richard Sts.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

DLL126 HEALTH DEPARTMENT—CITY OF BALTIMORE DLL126

18

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 E. Lombard ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie A. Sychuk

(Residence in Baltimore: No. 1827 E Lombard St ST.; yrs., mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec. 8, 1917
(Month) (Day) (Year)

7-AGE, yrs. mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) " " 000

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Mikhaj Sychuk.

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Michalina Parell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michalina Sychuk

(Address) 1827 E. Lombard.

15-

Filed ....., 191...

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1917, to Dec. 21 1917, that I saw h[illegible] alive on Dec. 20 1917, and that death occurred, on the date stated above, at 4 5 m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Chas Dyer M. D.

....., 191... (Address) 408 S Eden St Ka

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary

DATE OF BURIAL, Dec 23, 1917

20-UNDERTAKER William Fiery Sons

ADDRESS 1011 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 — REGISTERED NO. C 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Berman

(Residence in Baltimore: No. 812 Ashland St.; 12 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1905 (Year)

7-AGE, 12 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Myer Berman

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Minnie Berman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febuary 1917, to Dec 20 1917, that I saw h-- alive on Dec 20 1917, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis acute (staphylococcus viridans)

(Duration) 0 yrs. 10 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. Conrad M. D.

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. ds. In the State 12 yrs. 11 mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 812 Ashland St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rockburn DATE OF BURIAL, 12/23, 191.7

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

N. B.—Everything in [illegible] should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 11128.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D. 11128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 W. Lanvale ST.; 19 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret L. Harman.

(Residence in Baltimore: No. 1533 W. Lanvale St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. March (Month) 25 (Day) 1847 (Year)

7-AGE, About 70 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George Harman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Catherine Lord

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucelia Taylor

(Address) 1533 W. Lanvale St.

15- 2

Filed ....., 191.....

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NOTE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 12 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191.., to November 12, 191.., that I saw h.. alive on November 12, 191.., and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. Indefinite ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Brown Reed M. D.

Nov. 20, 191.. (Address) 1126 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount — DATE OF BURIAL, Dec. 22, 191..

20-UNDERTAKER J. B. Cook — ADDRESS 1033 Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D11120

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 ✓ D11120

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 N. Carolina ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bartman

(Residence in Baltimore No. 17 N. Carolina St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. 26, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. 2 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Box Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

463

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Bartman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Christina Ecker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Bartman

(Address) 17 N. Carolina St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 20 1917, that I saw him alive on Dec 20 1917, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1d ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) H. R. Russell M. D.

1701 ....., 191... (Address) 2411 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Carmel Cem	Dec 22, 1917.
20-UNDERTAKER	ADDRESS
Albert E Fuller	221 N Broadway

DEC 22 1917

middle c Miller

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 81 ✓ 011130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Fairmount Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Kniss

(Residence in Baltimore: No. 1418 Fairmount Ave St.; 68 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Oct (Month) 19 (Day), 1839 (Year)

7-AGE, 78 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 10 years

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Kniss

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kilgerman

(Address) 1408 E. Fairmount Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to December 19 1917, that I saw h in alive on Dec 19 1917, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Richard J. Eslinger M. D.

December 19 1917. (Address) 1514 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec 22, 1917

20-UNDERTAKER, F. Sander Sons

ADDRESS 1710 Reed St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 22 1917 ROBERT R. KRAUTER Burial Permit

D11131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D11131

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Stewart

(Residence in Baltimore: No. 1409 Appeale ~~Place~~ St.; yrs.. 9/12 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ~~Unknown~~ Unknown, 1909
(Month) (Day) (Year)

7-AGE: 8 yrs. ~~ mos. ~~ ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Stewart

(Address) 1409 Appeale Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) did find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration aorta
Shot by Alien Car

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. Fenton Finney M. D.
(Coroner)

Dec 20, 1917 (Address) 811 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel cmtry — DATE OF BURIAL, Dec 22 1917

20-UNDERTAKER Geo H Holland — ADDRESS 631 E Hoff

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11132 ✓ D11132

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E Chase ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Agusta Bonn

(Residence in Baltimore: No. 11 E Chase St ST.; 60 ? ? yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April (Month) 27 (Day) 1840 (Year)

7-AGE, 77 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~000~~ none
(b) General nature of industry, business, or establishment in which employed (or employer) ~~000~~ none

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Kemp

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Amanda Trail

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fannie A Rolling

(Address) 11 E Chase St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....1912, to Dec 21 1917, that I saw h.. alive on Dec 21 1917, and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

over

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute diffuse Nephritis

(Duration) yrs. mos. 5 ds.

(Signed) Geo. T. Kemp M. D.

Dec 21, 1917. (Address) St James Apartments

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Dec 24, 1917.

20-UNDERTAKER Stewart Mowen & Co ADDRESS 108 N North

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11133 92 D11133

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S Washington ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Francis Walsh

(Residence in Baltimore: No. 206 S. Washington St St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec 29, ~~1917~~ 1867
(Month) (Day) (Year)

7-AGE, 50 yrs. 11 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Office Work
(b) General nature of industry, business, or establishment in which employed (or employer): Roofing

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Walsh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Beechner

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Walsh

(Address) 206 S. Washington St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1917, to Dec 21 1917, that I saw h~~im~~ alive on Dec 21 1917, and that death occurred, on the date stated above, at 5 45 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Zabel M. D.

12/22, 1917. (Address) 1815 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, Dec 24, 1917.

20-UNDERTAKER Lilly & Zeile — ADDRESS 403 S. Wolfe St

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 22 1917 ROBERT E. KRAUSEN REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

D11131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 ✓ D11131

REGISTERED NO. C

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. ..... ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna Svrjcek

(Residence in Baltimore: No. 808 N. Bradford St.: 23 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 29 (Day), 1894 (Year)

7-AGE. 23 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James Mizerovsky

11-BIRTHPLACE OF FATHER (State or Country). Austria Bohemia

12-MAIDEN NAME OF MOTHER Anna Kulhanek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin W Svrcek

(Address) 808 N. Bradford St.

15-

Filed ....., 191.....

ROBERT R. KRAUTER
Burial Permit Clerk
DEC 22 1917

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14, 1917, to Dec 22, 1917, that I saw her alive on Dec 22, 1917, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Eclampsia Puerperal

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Renal & Insufficiency

Cardio Insuff. (Duration) 12 yrs. ..... mos. ..... ds.

(Signed) Hallie M Clark, M. D.

Dec 22, 191.7. (Address) Womans Hosp. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mos. 9 ds. In the State 23 yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? Womans Hospital

Former or usual residence Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL, Oak Hill — DATE OF BURIAL, Dec 24, 191.7

20-UNDERTAKER Frank Brock Sn — ADDRESS 1466 Garland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Bucc—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11135 D11135

CERTIFICATE OF DEATH.

10 ✓ REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Bruce ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Stearrow

(Residence in Baltimore: No. 620 Bruce St ST.; 32 yrs.,— mos. —ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Single

6-DATE OF BIRTH, ... 7 (Month) ..... 12 (Day), 1885 (Year)

7-AGE, ... 32 yrs. 5 mos. 8 ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Coal Seller
(b) General nature of industry, business, or establishment in which employed (or employer) 045

65

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Levi Stearrow

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co.

12-MAIDEN NAME OF MOTHER Charlotte Neal

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence E. Wright

(Address) 1364 N. Carey St.

15-

Filed ....., 191.....

Registrar.

DEC 22 1917 ROBERT E. KRAUTZ Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 12 (Month) ..... 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11th 1917, to Dec 20th 1917, that I saw him alive on Dec 19th 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Influenza Grippe

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) ..... C. W. Kantler M. D.

....., 191... (Address) 1403 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 22nd, 1917

20-UNDERTAKER Thomas E. Wright — ADDRESS Baynes

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11136

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

15 ✓ D11136

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 851 Greenmount ave ST. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Corbin

(Residence in Baltimore: No. 851 Greenmount ave St.; life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: white | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug (Month) 23, 1917 (Day, Year)

7 AGE: ..... yrs. 3 mos. 28 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Maryland Balto

PARENTS

10 NAME OF FATHER: A H Corbin

11 BIRTHPLACE OF FATHER (State or country): Va.

12 MAIDEN NAME OF MOTHER: Cassie Racey

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A H Corbin

(Address) 851 Greenmount Ave

15 Filed DEC 22 1917, 191 ROBERT E. KRAUSE Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 21 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 191 7, to Dec 21 191 7, that I saw h-m alive on Dec 21, 191 7, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Acute Congestion of Lungs

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Improper feeding

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) James M Fenlon M. D.

Dec 21, 191 7 (Address) 702 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore | DATE OF BURIAL: Dec. 22 1917

20 UNDERTAKER: H. C. Wardefield | ADDRESS: 19 Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11137 7 ✓ 30 D11137 7

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp ST.; Cast WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E Holzner

(Residence in Baltimore: No. 125 E. Ostend St St.; yrs., Life mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 26, 1912 (Month) (Day) (Year)

7-AGE, 5 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... — 000

000

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Henry Holzner

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Kath. Lounbard

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kath. Holzner

(Address) 125 E. Ostend St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 21 1917, that I saw him alive on Dec 21 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) T.B. Meningitis

(Duration) yrs. mos. ds.

(Signed) H. Merkel M. D.

....., 191... (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State 5 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 125 E Ostend St

19-PLACE OF BURIAL OR REMOVAL. Balto Cemetery

DATE OF BURIAL. Dec 24 1917.

20-UNDERTAKER F A Strauss

ADDRESS 1030 Hanover

5

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 ✓ 8

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 518 Pierce St ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine E. Banner

(Residence in Baltimore: No. 518 Pierce St St.: yrs. 9/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 COLOR OR RACE: col

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): mdw

6 DATE OF BIRTH: Feb 12 th, 1865 (Month) (Day) (Year)

7 AGE: 52 yrs. 10 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Arthur Brown

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mat Ford

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George W. Brown

(Address) 513 Pierce St.

15

Filed , 191 REGISTRAR

DEC 22 1917 ROGERS B. ERAUTER
Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 21 st, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1917, to Dec 21 st 1917 that I saw h.r alive on Dec 21 st, 1917, and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Hemiplegia ovw (Duration) yrs. 5 mos. ds

Contributory (SECONDARY) Aphasia (Duration) yrs. 5 mos. ds.

(Signed) L. B. Evans M. D.

, 191 (Address) Evans & Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 24, 191 9

20 UNDERTAKER: Daniel Easter Co — ADDRESS: 912

Spec.—8-24-14—M. & T.—2000 Bks.

D11139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11139

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.; 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Hart

(Residence in Baltimore: No. 1068 Forest St St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) Jan (Day) ....., 1887 (Year)

7-AGE, 30 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Hand

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hand

(Address) 1008 Forest St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Dec (Day) 21, (Year) 1917

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 21 1917, that I saw him alive on Dec 21 1917, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H Merkel M. D.

Dec 21, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 21 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Dec. 24th, 1917.

20-UNDERTAKER H Fahey & Sons

ADDRESS 106 Lafayette Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11140 11140

CERTIFICATE OF DEATH.

REGISTERED NO. C 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 Hanover ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Mason

(Residence in Baltimore: No. 425 Hanover St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 11, 1900
(Month) (Day) (Year)

7-AGE, 17 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm E. Mason

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Stella Hipsley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice E. Mason

(Address) 425 Hanover St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, [redacted]ember 22d, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17th 1917, to Dec 22d 1917, that I saw h[redacted] alive on Dec 21st 1917, and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Pericarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malarial Cachexia

(Duration) yrs. 3 mos. ds.

(Signed) Edw. M. Ingraham M. D.

Dec 22, 1917. (Address) 5 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. County

DATE OF BURIAL, ..., 191...

20-UNDERTAKER George J[illegible]

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 N Stricker St (ST.) 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Billmann

(Residence in Baltimore: No. 17 N Stricker St. St.; 16 yrs. — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 3rd (Month) (Day), 1827 (Year)

7-AGE, 90 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Commission Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Geo. Billmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Billmann

(Address) 17 N. Stricker St

15-

Filed..... 191.....

DEC 22 1917 ROBERT B. KRAMER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 21st (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 17 1917, to Dec, 21st 1917, that I saw h m alive on Dec, 21st 1917, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Old age and General debility

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusions of right hip age + inanition

(Duration)..... yrs. mos. ds.

(Signed) Chas Baltzmann M. D.

Dec 22, 1917. (Address) 700 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Milwaukee Wis.	Dec 24, 191...
20-UNDERTAKER	ADDRESS
Geo. H. Schmick & Son	700 W Lafayette

D1112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1112

CERTIFICATE OF DEATH.

172

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Mercy Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Davis,

(Residence in Baltimore: No. 1310 Homestead Pl St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 12, 1886
(Month) (Day) (Year)

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Fireman
(b) General nature of industry, business, or establishment in which employed (or employer), R.R. 086

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas Davis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwina Davis

(Address) 1310 Homestead Pl

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock
Train engine Struck
Accident (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)
Dec 21, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec 22, 191.7

20-UNDERTAKER G.B. Redfearn

ADDRESS 2236 Fredk Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D1143

43 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3013 Westwood Ave St. 15 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles M Johannes

(Residence in Baltimore: No. 3013 Westwood Ave St.) (51 yrs. 4 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE MARRIED WIDOWED DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: July 29th (Month) (Day), 1866 (Year)

7-AGE: 51 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Fireman 032
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore Fire Dept

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Chas M Johannes

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Mary A Langdon

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ida M Johannes

(Address) 3013 Westwood Ave

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 19 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 1, 1917, to Dec 19 1917.

That I saw him alive on Dec 19, 1917.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Mitral + Aortic Insufficiency

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY) Acute Influenza

Pneumonia (Duration) yrs. 2 mos. ds.

(Signed) Irvin Etzwiler M. D.

Dec 20, 1917 (Address) 700 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Dec 22 1917

20-UNDERTAKER: Geo A Gerbig — ADDRESS: Baltimore

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1141 — 154 — D1141

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Linden Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Harvey

(Residence in Baltimore: No. 1010 Linden Ave St.; 9 yrs. 0 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Colord

5-~~SINGLE,~~ MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 78 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Farmer

014

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Richard Harvey

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Daughter Edith Harvey

(Address) 1010 Linden Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1917, to Dec 21 1917, that I saw h[im] alive on Dec 20 1917, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. McCarl M. D.

12/21, 191.7. (Address) 1001 W Fillmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Glorian — DATE OF BURIAL, Dec 23, 1917.

20-UNDERTAKER Edward W Pyle — ADDRESS 903 Edmondson Catonsville Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dec 24 1917 ROBERT B. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D1145 D1145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2037 Gough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida E. Smith

(Residence in Baltimore: No. 2037 Gough St. Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	White	Married

6-DATE OF BIRTH, July 25 (Month), (Day), 1861 (Year)

7-AGE,	If LESS than 1 day,
56 yrs. 4 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Benjm Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Christina Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. E. Smith

(Address) 2037 Gough St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, (Month), (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1916, to Dec 20 1917, that I saw h[illegible] alive on Dec 20 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

.....

.....

Intestinal Hemorrhage

..... (Duration) 1 yrs. 10 mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac & Nephritis

..... (Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

Dec 22, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cem	Dec 24, 1917

20-UNDERTAKER	ADDRESS
Robt F Turner	424 Broadway

DEC 22 1917 ROBERT R. KRAUTER Registrar Private Practice

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Hanover St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Callaghan

(Residence in Baltimore: No. 1617 Hanover St. St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, Nov 8, 1830
(Month) (Day) (Year)

7-AGE, 67 yrs. 1 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired. 3
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Callaghan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Rodgers

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Darcy

(Address) 1617 Hanover St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1917, to Dec 20 1917, that I saw h in alive on Dec 20 1917, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) ..... Influenza

(Duration) ..... yrs. 1 mos. 1 ds.

(Signed) ..... M. D.

12-21, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral DATE OF BURIAL, Dec. 23 1917

20-UNDERTAKER Robt. J. Turner ADDRESS 1742 Broadway

NOTE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1122 Woodyear ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Robinson

(Residence in Baltimore: No. 1122 Woodyear St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1876 (Year)

7-AGE. 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nurse 037
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country), Balt. City

PARENTS.

10-NAME OF FATHER, Geo. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Small

13-BIRTHPLACE OF MOTHER (State or Country), Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) 1122 Woodyear

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Called to Heaven

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 22, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State Born yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 27 1917

20-UNDERTAKER Samuel T Moseley — ADDRESS 578 N Broadway

DEC 22 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

D1114S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1114S

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Page #2

(Residence in Baltimore: No. 1933 Lemmon St.; yrs., mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. 11-23-17 (Month) (Day) 1917 (Year)

7-AGE. yrs. mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. W D Page

11-BIRTHPLACE OF FATHER (State or Country). Baltic

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltic

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R Brooks

(Address) Calhoun & Baltimore

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 21, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1917, to Dec 21 1917, that I saw her alive on Dec. 21 1917, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Bruce Robertson M. D.

12/21, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 29 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. 12-22, 1917.

20-UNDERTAKER Robert Brooks & Son

ADDRESS 178 Calhoun St

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 22 1917 [illegible]

D1149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D1149

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2233 Preston Place ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Grotman

(Residence in Baltimore: No. 2233 Preston Place St.; 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... November ....., 1878
(Month) (Day) (Year)

7-AGE, ... 38 ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nathan Krasin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Esther Engst

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... L. Lewis .....

(Address) ..... 611 E. Baltimore .....

15-

DEC 22 1917

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 20 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Organic Heart Disease .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

12-22-17, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Markendale McCord	....., 19....
20-UNDERTAKER Jack Lewis	ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

011150

HEALTH DEPARTMENT—CITY OF BALTIMORE

011150

CERTIFICATE OF DEATH.

109

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Markowitz

(Residence in Baltimore: No. 224 N. Wolf Street

St.: 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, Unknown, 1854
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 1037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 141 E. Lombard St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1917., to Dec. 21 1917, that I saw her alive on Dec. 21 1917, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Whitridge Hurd M. D.

Dec 21, 1917 (Address) 3 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 224 N. Wolf St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Wilson	Dec. 24, 1917.

20-UNDERTAKER J. Lewis ADDRESS 141 E. Lombard

N. B.—Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D1151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1151

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CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 S. Conkling ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Lang

(Residence in Baltimore: No. 806 S. Conkling St.; ...yrs,, ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 4 (Day), 1836 (Year)

7-AGE, 81 yrs. 6 mos. 17 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

000 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Dillerman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth K. Zimmerman

(Address) 806 S. Conkling St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 21st, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 7 1917, to Dec. 21 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: 5a.

Cerebral Hemorrhage

..... (Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Chas Allen M. D.

12/23/17, 191... (Address) 408 S. Bst. B'K. Cm...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem | DATE OF BURIAL, Dec. 24, 191.7

20-UNDERTAKER Jos. J. Hess | ADDRESS 156 N. Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11152

D11152

CERTIFICATE OF DEATH.

REGISTERED NO. C 67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N. Patterson Pk. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia E. Dietz

(Residence in Baltimore: No. 608 N. Patterson Pk. ave St.; 40 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec. (Month) 5 (Day), 1855 (Year)

7-AGE, 61 yrs. mos. 15 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Ger.

PARENTS.

10-NAME OF FATHER, Nicholaus Vogel

11-BIRTHPLACE OF FATHER (State or Country), Ger.

12-MAIDEN NAME OF MOTHER Johanna Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John Dietz

(Address) 608 N. Patterson Pk ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1916, to Dec 20 1917, that I saw h[illegible] alive on Dec 19 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Arteriosclerosis (Duration) 2 yrs. mos. ds.

(Signed) Albert E. Lehman M. D.

Dec 21, 1917. (Address) 718 N. Fifteenth St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer cem	Dec. 24., 1917
20-UNDERTAKER	ADDRESS
Jos. J. Kerr	1566 N. Luzerne

D1153

HEALTH DEPARTMENT—CITY OF BALTIMORE

154

D1153

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 219 S Regester St ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Schwankoska

(Residence in Baltimore: No. 219 S Regester St

36 ~ Sr.; yrs., mos. da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, ... Not Known ....., 1 .....
(Month) (Day) (Year)

7-AGE, 75 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000 000

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Frank Marcinek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Buchlaska

(Address) 219 S Regester St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Lynch Dunn Co. D.

Dec 27 1917. (Coroner) (Address) 1610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER Jacob Frankowski

ADDRESS 118 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11154

CERTIFICATE OF DEATH.

119 D11154

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Hillman ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Jones

(Residence in Baltimore: No. 1307 Hillman St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 9, 1895
(Month) (Day) (Year)

7-AGE, 22 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Waits

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Margt Brady

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Chase

(Address) 1307 Hillman St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC 19 1917
DEC 19 1917
DEC 19 1917
DEC (Month) 19 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from OCT 30 1917 191..., to ....191...,
that I saw HER alive on ....191...,
and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Uremia

.....(Duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

.....(Duration) X yrs. 3 mos. 19 ds.

(Signed) O. H. Duker M. D.

DEC 21 1917, 191... (Address) 926 E. NORTH AVE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, DEC 24 1917

20-UNDERTAKER Roby Redeman — ADDRESS Green Mt Ave

P. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11155 — 170 D11155

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 342 East 25th St. 17 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles A. Rimmel. Off

(Residence in Baltimore: No. 342 East 25th St.: Yrs. ..... mos. ..... ds.)

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): married

6 DATE OF BIRTH: Sept. 27, 1867 (Month) (Day) (Year)

7 AGE: 50 yrs. 2 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk 089
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Office

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Rimmel.

11 BIRTHPLACE OF FATHER (State or country): Berlin, Germany.

12 MAIDEN NAME OF MOTHER: Rosa Reichel.

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Catherine F. Rimmel
(Address): 342 E 25th St.

15.
Filed ....., 191.....
REGISTRAR

DEC 23 1917 JOSEPH E. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 21, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1917, to Dec 21 1917, that I saw him alive on Dec 21, 1917, and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) ..... yrs. ..... mos. 14 ds

Contributory (SECONDARY): Chr. Diffuse Nephritis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Chas E. O'Neill M. D.

Dec 21, 1917 (Address) 1508 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 24, 1917

20 UNDERTAKER: C. A. Medefield Jr. — ADDRESS: 2245 Eutaw Pl

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11156

CERTIFICATE OF DEATH.

11156 1920 D11156

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 Calverton Rd. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earnest Tucker

(Residence in Baltimore: No. 148 Calverton Rd St.; 5 yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH Oct. 22, 1884.
(Month) (Day) (Year)

7-AGE, 33 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Foreman 086
(b) General nature of industry, business, or establishment in which employed (or employer) Rubber Factory 284

9-BIRTHPLACE, (State or Country), Baltimore Co Md.

PARENTS.

10-NAME OF FATHER, Robert L. Tucker

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md.

12-MAIDEN NAME OF MOTHER, Elizabeth E. Hobbs

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Tucker

(Address) Alberton Md.

15-

Filed....., 191.....

Registrar.

DEC 23 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 18, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1917, to Dec 18 1917, that I saw h[illegible] alive on Dec 18 1917, and that death occurred, on the date stated above, at 5 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis about one mo.

(Duration) yrs. mos. ds.

(Signed) C. B. S. Nesbitt M. D.

Dec 19, 1917. (Address) Garrison & Cold

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cannot be found

19-PLACE OF BURIAL OR REMOVAL, Grd Stuched Cemetery — DATE OF BURIAL, Dec 22 1917

20-UNDERTAKER Geo L Schmidt & Bro — ADDRESS 1901 Eutaw Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11157

CERTIFICATE OF DEATH.

97 D111537

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Paul Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Coretta Clark

(Residence in Baltimore: No. 2037 Ellsworth St.; 40 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 4 (Day) 1879 (Year)

7-AGE, 38 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country). Balto Maryland

PARENTS.

10-NAME OF FATHER, John R. Smith

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Lizzie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Clark

(Address) 2037 Ellsworth St

15-

DEC 23 1917 ROBERT B. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 22 1917, that I saw h[illegible] alive on Dec 22 1917, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Frank Tuberculosis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Walter Barnes M. D.

Dec 22, 1917. (Address) 1218 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2037 Ellsworth St

Former or usual residence 2037 Ellsworth St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cem	12/25, 1917
20-UNDERTAKER Wallace Cook	ADDRESS 508 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11158

CERTIFICATE OF DEATH.

D11158

1-PLACE OF DEATH Md. General Hospital.

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 4 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Ware.

(Residence in Baltimore: No. 311 Hargrove St.; Life yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, ...Unknown...., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
3 yrs. mos. da.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Henry Ware

11-BIRTHPLACE OF FATHER (State or Country), Baltimore md

12-MAIDEN NAME OF MOTHER Cornish

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Ware

(Address) 311 S. Hargrove alley

15- 8 5

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...December 21....., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1917, to Dec 21 1917, that I saw h.. alive on Dec 21 1917, and that death occurred, on the date stated above, at 1.45 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

..... (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis of Aort. Valve (Duration) yrs. mos. ds.

(Signed) Harry Beck M. D.

12-21, 191.7. (Address) Linden Ave & Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 33 da. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn cemetery

DATE OF BURIAL, Dec. 24 1917.

20-UNDERTAKER Filip B. Pyle

ADDRESS 102 E. Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Betty Chase

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11159

CERTIFICATE OF DEATH.

166 D11159

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty ~~Matilda~~ Chase

(Residence in Baltimore: No. 211 Rock St.; 70 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer) "

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Naylor

(Address) 501 W Lanvale

15-

Filed....., 191.....

Registrar.

DEC 23 1917 ROBERT B. KRAUTER Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation caused by inhaling smoke, due to fire, (accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. S. Driscoll M. D. (Coroner.)

Dec 22 1917. (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 23 1917

20-UNDERTAKER J. W. Loader

ADDRESS 1,4½ Lexington

A. D. Driscoll, M. D. being first duly sworn upon his oath deposes and says that he is the same party named in the Coroner's Certificate of Death, who took charged of the remains of Betty Chase of 211 Rock Street; that he by mistake placed the name of the deceased as Matilda Chase Whereas it should have been Betty Chase.

Dr. A. D. Driscoll
Affiant

TEST:-
Carlos E Jennings

Subscribed and sworn to before me this 27th day of December A. D. Nineteen Hundred and Seventeen.

Carlos E Jennings
Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11160

CERTIFICATE OF DEATH.

D11160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Jefferson St.; 7 WARD) REGISTERED No. C 120

2-FULL NAME Bailey Rasa Chidchekel

(Residence in Baltimore: No. 1500 Jefferson St.; 14 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1 (Year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12 1917, to Dec 21 1917, that I saw her alive on Dec 21 1917, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. L. Hamsteins M. D.

12/22, 1917. (Address) 733 Augusta St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Weber Rosedale — DATE OF BURIAL, 12/23, 1917

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

DEC 23 1917 ROBERT D. KRAUTER REGISTRAR OF VITAL STATISTICS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Annie Schemm

Spec.—8-24-14—M. & T.—2000 Bks.

D11161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11161

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Hanover St.; ... WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Schemm

(Residence in Baltimore: No. 1701 Hanover St.; 57 yrs., ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 11, 1848 (Month) (Day) (Year)

7-AGE, 69 yrs. 5 mos. 11 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Chas. Bradley

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs P. Kaufman

(Address) 1701 Hanover St.

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1917, to Dec 22 1917, that I saw h[illegible] alive on Dec 22 1917, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. 2 ds.

(Signed) H. E. L. Campbell M. D.

Dec 22 191 7 (Address) 164 E Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	..., 191...
20-UNDERTAKER L. Schumacher	ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11162

CERTIFICATE OF DEATH.

79

D11162

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 W North ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles P. Cleaveland

(Residence in Baltimore: No. 819 W North ave St.; 62 yrs., 6 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 10th (Day), 1855 (Year)

7-AGE. 62 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Court Clerk 086
(b) General nature of industry, business, or establishment in which employed (or employer): Court of Common Pleas

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Sylvester Cleaveland

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Virginia L Lockey

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella B Cleaveland

(Address) 819 W North ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1917, to Dec 21 1917, that I saw him alive on Dec 21 1917, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry C. Clark M. D.

Dec 22, 1917 (Address) 701 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	Dec 24, 1917.
20-UNDERTAKER	**ADDRESS**
George J Kilby & Sons	1126 Monument

DEC 25 1917 ROBERT T. STANTON Vital Statistics

Spec. No. 24-14—M. & T.—2000 Blks.

Mariah Hill

D11163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D11163

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Bridle ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mariah Hill

(Residence in Baltimore: No. 108 Bridle St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... December (Month) ..... (Day) 1870 (Year)

7-AGE,	If LESS than 1 day,
46 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Tinsley

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mrs. D. Hill

(Address) 108 Bridle St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 20 (Month) (Day) ....., 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1917, to Dec. 20th 1917, that I saw h.. alive on Dec. 16th 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

..... Tuberculosis Pneumonia

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem — DATE OF BURIAL, 12/23, 1917

20-UNDERTAKER, Daniel Stanley — ADDRESS 578 N Bridle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11161

CERTIFICATE OF DEATH.

D11161

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Huffer

(Residence in Baltimore: No. 5246 Main St. Edington, Balto. Md St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) Aug. (Day) 21, (Year) 1853

7-AGE, 64 yrs. 4 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car Cleaner 086
(b) General nature of industry, business, or establishment in which employed (or employer): U.R.R. Co. 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph L. Huffer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catherine Mullen

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Fee

(Address) 5246 Main St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1917, to Dec. 9, 1917, that I saw h[illegible] alive on Dec. 9, 1917, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H. Smith M. D.

Dec 13, 1917 (Address) Millington Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. 5 mos. ..... ds.

Where was disease contracted, if not at place of death? 5246 Main St. Edington Md

Former or usual residence 5246 Main St. Edington Md

19-PLACE OF BURIAL OR REMOVAL, Middletown Md. DATE OF BURIAL, Dec. 13, 1917.

20-UNDERTAKER E. B. Bank ADDRESS 164 West St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11165 PLACE OF DEATH

CERTIFICATE OF DEATH

92 REGISTERED NO. D11165

CITY OF BALTIMORE (No. 207 S. Chapel St. 2 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Daniel Williams

(Residence in Baltimore: No. 207 S. Chapel St. One yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): child

6 DATE OF BIRTH: March (Month) 7 (Day), 1914 (Year)

7 AGE: 3 yrs. Elev 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nathaniel Williams

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Young

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josephine Williams

(Address) 207 S Chapter St

15.

Filed ....., 191 ..... REGISTRAR

DEC 23 1917 ROBERT B. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 21 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1917, to Dec 21 1917, that I saw h in alive on Dec 21, 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds

Contributory (SECONDARY): none

(Duration) yrs. mos. ds.

(Signed) Herman Seidel M. D.

Dec 21, 1917 (Address) 1931 E. Pratt st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Asbury Cem

DATE OF BURIAL: Dec 23 ....., 191....

20 UNDERTAKER: Harry A Vodery

ADDRESS: 1725 Alison st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11166

CERTIFICATE OF DEATH.

D11166

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Scott St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Gaull.

(Residence in Baltimore: No. 1203 Scott St. St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Married

6-DATE OF BIRTH, Dec. (Month) 2 (Day), 1857 (Year)

7-AGE, 60 yrs. ....mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John Gaull

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gaull

(Address) 20 Old Town Rd

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 22 (Day), 1917 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 22 1917, that I saw him alive on Dec 22 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. C. Trulinger M. D.

12-22-, 191.7. (Address) 652 Columbia Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec. 25, 191.7.
20-UNDERTAKER	ADDRESS
Wm Cook & Son	Pratt & Paca

Spec.—[illegible]—M. & T.—[illegible] Blks.

D11167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/5 D11167

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 N Milton Ave St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M Wheeler

(Residence in Baltimore: No. 1135 N Milton Ave St.: 10 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 12, 1872 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Work 037

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Robt A Dinsmore

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Agnes M Watson

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna M Keeler

(Address) 1135 N Milton Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1917, to Dec 22 1917, that I saw her alive on Dec 22 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

Acute

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo D Yeomans M. D.

Dec 23, 1917 (Address) 1532 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Delta Pa — DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER William Lock — ADDRESS 502 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Henry E. Scholz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11168

D11168

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2144 S Charles ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry E Scholz

(Residence in Baltimore: No. 2144 S Charles St.; 76 yrs., 6 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 15, 1841 (Month) (Day) (Year)

7-AGE, 76 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tinsmith
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fanny Scholz

(Address) 2144 S Charles

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1917, to Dec 22 1917, that I saw h alive on Dec 22 1917, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. mos. 1 ds.

(Signed) R L Campbell M. D.

Dec 22 1917 (Address) 1606 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill | DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER Wm E Evans | ADDRESS 423 Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11169

CERTIFICATE OF DEATH.

161 D11169

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Boker #1

(Residence in Baltimore: No. 715 E. Baltimore St.; 1yr yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 13 (Month) (Day), 1917 (Year)

7-AGE, ...yrs...mos...ds.

If LESS than 1 day, 3 hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Herman Boker

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rae Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address) Hebrew Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 13 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13 1917, to Dec. 13 1917, that I saw him alive on Dec. 13 1917, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (8 mos.)

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Atelectasis of Lungs

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) B Bacon M. D.

Dec 13, 1917. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 3hrs. ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Workmens Circle Mt. Carmel Rd. DATE OF BURIAL, Dec 23., 1917.

20-UNDERTAKER Jack Sewes ADDRESS 1411 E Balto.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11170

CERTIFICATE OF DEATH.

79. D11170

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 W. Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisha Samuel Taylor

(Residence in Baltimore: No. 1515 W. Lombard St. 26 yrs., 4 mos. 1 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH. June 1, 1863
(Month) (Day) (Year)

7-AGE. 54 6 23
yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Dentist
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Daniel Taylor

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Esther Bennett

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate L. Taylor

(Address) Mardela Springs

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Decem 23 1917, that I saw him alive on Dec 22 1917, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W. Jones M. D.

Dec 23 191 7 (Address) Pocomoke

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mardela Springs | DATE OF BURIAL, ..., 191...

20-UNDERTAKER George Smith & Son | ADDRESS

DEC 24 1917 ROBERT B. KRAUTER REGISTRAR OF VITAL STATISTICS

Spec.—8-24-14—M. & T.—2000 Bks.

D11171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113. D11171

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 N Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Berger

(Residence in Baltimore: No. 1846 N Gay St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, Sept 01, 1863
(Month) (Day) (Year)

7-AGE, 54 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Germania Hall

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, William Berger.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmanuel Berger

(Address) 1846 N Gay.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 20 1917, that I saw h.. alive on Dec 20 1917, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

.....

..... Cellerous Liver

..... (Duration)..yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pericarditis

..... (Duration) yrs. 1 mos.....ds.

(Signed) C. L. Long M. D.

12-21., 1917.. (Address) 2701 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem — DATE OF BURIAL, Dec 24., 1917..

20-UNDERTAKER J. Herwig & Co — ADDRESS 2008 Aliceanna

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11172

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Karl G. Daab

(Residence in Baltimore: No. 6 Day's St.; .....yrs., ...mos. .....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan 13 ....., 1901
(Month) (Day) (Year)

7-AGE. ..16.. yrs. ..6.. mos. ..10.. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE. (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Henry A. Daab

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Lizzie Daab.

13-BIRTHPLACE OF MOTHER (State or Country), N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry A. Daab.

(Address) La Fargeville N. J.

15-

Filed....., 191.....
Registrar.

DEC 2 1 1917 ROBERT P. LI. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 23 ....., 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17th 1917, to Dec 23 1917, that I saw him alive on Dec 23 1917, and that death occurred, on the date stated above, at p m.

The CAUSE OF DEATH* was as follows:

..... Brain Tumor .....

.....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Operation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... C. E. Ward Jr. ..... M. D.

Dec 23, 1917. (Address) John Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 6 ds.

Where was disease contracted, if not at place of death? 3

Former or usual residence La Fargeville N. J.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
La Fargeville N Y.	Dec. 24....., 1917.
20-UNDERTAKER	ADDRESS
Alfred C. Fuller	221 N Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11173

CERTIFICATE OF DEATH.

151

D11173

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Ashland Ave St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine & Charles H. Spalin

(Residence in Baltimore: No. 1416 Ashland ave St.; ....yrs., ...mos., 1 day ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 23 1917
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles H. Spalin

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Catherine Denhardt

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Charles H. Denhardt

(Address) 1416 Ashland Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191.., to ....191..,
that I saw h.. alive on Dec 23 191 7,
and that death occurred, on the date stated above, at 1 9 m.
The CAUSE OF DEATH* was as follows:

Laceration Birth
Died 1 hour
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Gustav H. Wolters M. D.
Dec 23, 1917. (Address) 1210 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Dec 24..., 1917.

20-UNDERTAKER Henry Koeckes Son — ADDRESS 1301 E Eager St

DEC 24 1917 ROBERT B. KRAUER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9r D11174

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Warner ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver Hammond Dorsey

(Residence in Baltimore: No. 16 B Warner St.; Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	Colored	single

6-DATE OF BIRTH. ..12.. (Month) ..9.. (Day), 1917 (Year)

7-AGE. .....yrs. .....mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country). Balto Maryland.

PARENTS.

10-NAME OF FATHER. Oliver Hammond.

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Jennie Dorsey

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. H. Fisher

(Address) 1615 Warner St. Balto

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..12.. (Month) ..22.. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 19 1917, to Dec 21 1917, that I saw h in alive on ~~Dec~~ Dec 21 1917, and that death occurred, on the date stated above, at 11.4 m.

The CAUSE OF DEATH* was as follows:

Disease — Tobacco Pneumonia.

Immediate Exhaustion

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 24 1917.

20-UNDERTAKER Jos L Brown & Son — ADDRESS 106 N. Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1132 Lauvel St.; 5 WARD)

REGISTERED NO. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Jones

(Residence in Baltimore: No. 1132 Laurel St., Same)

30 St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, ... September, 1 .....
(Month) (Day) (Year)

7-AGE, ...46....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dancer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home 070

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Julian Burt

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Gonzales

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Virginia Bates

(Address) 1132 Laurel St.

15-

Filed....., 191.....
Registrar.

DEC 24 1917 ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 21 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inq .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... Inq .....
(Inquest, autopsy or inquiry.) found that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Chronic Nephritis .....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

Dec 21, 191.., (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Dec. 24, 1917

20-UNDERTAKER Robert W Henderson

ADDRESS 519 Caroline

D11176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D11176

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital ST.; 21 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Keyser

(Residence in Baltimore: No. 1115 Ridgley St.; yrs. Life mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Single.

6-DATE OF BIRTH. March 14, 1869
(Month) (Day) (Year)

7-AGE, 48 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd
243

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, William F. Keyser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emily Lynch

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Mills
(Address) 1115 Ridgley

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH December 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following fracture of Skull. Caused by being struck by automobile (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....
(Duration)..... yrs..... mos..... ds.

(Signed) A. E. Driscoll M. D.
(Coroner)
Dec 22, 191. (Address) 120 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	12-24 1917
20-UNDERTAKER	ADDRESS
J. Geo McCully	130 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11177

CERTIFICATE OF DEATH

+120

D11177

REGISTERED NO. C

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Eutaw Place & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Alfred P Corlett

(Residence in Baltimore: No. Cecil County Md St.; ..... yrs., ... mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month), ... (Day), 1877 (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ..... mos. ..... ds.	....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Harle

(Address) 115 E. West St.

15-

Filed ...., ..., 191.....

Registrar.

DEC 24 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27 1917, to Dec 24 1917, that I saw h[illegible] alive on Dec 24 1917, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Cardiac Dilatation
..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Roberts M. D.

12-24, 1917 (Address) Md General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 27 ds. In the State 40 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Cecil County Md.

19-PLACE OF BURIAL OR REMOVAL, Mount Egypt Cem. Co. Lawyers Lot Thurmont

DATE OF BURIAL, Dec. 26, 1917

20-UNDERTAKER E. H. Harle

ADDRESS 115 E. West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11178

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.; Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Morris

(Residence in Baltimore: No. 1615 Light St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) sngl

6-DATE OF BIRTH, Sept. (Month) 11 (Day), 1896 (Year)

7-AGE, 21 yrs. 3 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car conductor
(b) General nature of industry, business, or establishment in which employed (or employer): 078

532

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, B. A. Morris

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Edith Cloninger

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. T. Morris

(Address) North Carolina

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Filed....., 191.....

Registrar.

DEC 24 1917 ROBERT R. KRAUTER REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1917, to Dec 23 1917, that I saw him alive on Dec 23 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Benj. M. [illegible] M. D.

Dec 24, 1917. (Address) Md General Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at city home

Former or usual residence Staunton - N. C.

19-PLACE OF BURIAL OR REMOVAL, Stanley North Carolina

DATE OF BURIAL, 12/27 1917

20-UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fort.

Spec.—8-24-14—M. & T.—2000 Bks.

D11179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Summers (Summers)

(Residence in Baltimore: No. 1622 D. Hill ave. St.; Type yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widr

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1837 (Year)

7-AGE. 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). 620

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Pullen

(Address) 1622 Druid Hill ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 22 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-20-17 191, to 12-22-17 191, that I saw h[illegible] alive on 1 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) F. H. Claudon M. D.

12-22-17 191... (Address) 1624 D. Hill ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER John H. Frazier — ADDRESS 142 N. Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 24 1917 ROBERT B. KRAUTER

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11180

D11180

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2922 Bernard ST., WARD 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence R. Seitz

(Residence in Baltimore: No. 2922 Bernard St St.; 9/12 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Dec 31, 1916 (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Son
(b) General nature of industry, business, or establishment in which employed (or employer). 000

000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Seitz

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Beulah Walker

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Seitz

(Address) 2922 Bernard St.

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1917, to Dec 22 1917, that I saw him alive on Dec 22 1917, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) 2 weeks yrs. mos. ds.

(Signed) F. A. Reichelderfer M. D.

Dec 23, 1917. (Address) 112 W 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Dec 24 191 7

20-UNDERTAKER Edw Roy Stiffler ADDRESS 125 N Howard

Spec.—8-24-14—M. & T.—2000 Bks.

D11181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D11181

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Marie Herman

(Residence in Baltimore: No. 750 W. Saratoga St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ...18....99...., 1.....
(Month) (Day) (Year)

7-AGE, ..18..yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, J. Morgan

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER J. Worsham

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Morgan

(Address) 750 W. Saratoga

15-

Filed....., 191.....
Registrar.

DEC 24 1917 ROBERT B. HEALTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/30 1917, to 12/23/ 1917, that I saw h[illegible] alive on 12/23/ 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

.....Peritonitis

.....

.....

..... (Duration) ...yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Perforated Gallbladder

..... (Duration) ...yrs. 1 mos. ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion — DATE OF BURIAL, Dec 27, 191.7

20-UNDERTAKER Daniel Carlin — ADDRESS 916 Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11182 **CERTIFICATE OF DEATH.** 151 D11182

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Dixon

(Residence in Baltimore: No. 640 Granville's Ln. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Dec 15, 1917
(Month) (Day) (Year)

7-AGE, # yrs. # mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0 0

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Arthur Dixon

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Adelaide Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adelaide Dixon

(Address) 640 Granville's Ln.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 21 1917, that I saw him alive on Dec 21 1917, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

1. Premature Birth

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward A. Dutch M. D.

Dec 21, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State ....yrs. ....mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 24 1917 JOHNS HOPKINS HOSPITAL ROBERT E. TRAITEN Commissioner of Health.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11183 HEALTH DEPARTMENT—CITY OF BALTIMORE D11183

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie Bitters (BITTER)

(Residence in Baltimore: No. 24 N. Lakewood Ave St.; 56 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct. 5, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. 2 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 600

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Duffy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Mahon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lorette Bitter

(Address) 24 N. Lakewood Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 23 1917, that I saw her alive on Dec 23 1917, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) typhoid Status Congestum

(Duration) ....yrs. ....mos. 6 ds.

(Signed) A Merkel M. D.

Dec 23, 1917. (Address) St Josephs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 12/24....., 191.7.

20-UNDERTAKER Henry W. Meade & Son

ADDRESS 1050 Eutaw

DEC 24 1917 ROBERT R. KRAUTER BURIAL PERMIT CLERK

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11184

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette Sts ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Wonderly

(Residence in Baltimore No. 60 Washington Ave Int Washington St.; 3 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, 5 (Month) 2 (Day), 1854 (Year)

7-AGE, 63 yrs. 7 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jno S Wonderly

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elmira Cummins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cary Wonderly

(Address) Int Washington

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 20 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1917, to Dec 20 1917, that I saw h.. alive on Dec 20 1917, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus Coma

Exhaustion

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion

..... (Duration) yrs. mos. 14 ds.

(Signed) C. H. Bolton M. D.

12-20, 1917. (Address) Int Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec. 24, 1917.

20-UNDERTAKER John O. Mitchell — ADDRESS 120 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11185 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

X 28 D11185

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1614 E. Chas St. 8th WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary F. Boyer

(Residence in Baltimore: No. Perrymans Harford Co, Md St.; 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH December 7th, 1847 (Month) (Day) (Year)

7-AGE 70 yrs. mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Packing Business
(b) General nature of industry, business, or establishment in which employed (or employer) Partner

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER John Yellman

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER ~~Mary Fuetina~~ Unknown Yellman

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. H. Boyer

(Address) Perrymans. Md.

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec. 22, , 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1917, to Dec. 22, 1917, that I saw h[er] alive on Dec. 21, , 1917, and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia
(Intercurrent)
(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Pneumo-Thorax
(Duration) ..... yrs. ..... mos. 9 ds.

(Signed), S. S. Rush M. D.

Dec. 22, 1917 (Address) Chas. & Preston Sts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) Only in city 9 days

At place of death ..... yrs. ..... mos. 4 ds. In the State 70 yrs. mos. 15 ds.

Where was disease contracted, if not at place of death? unknown.

Former or usual residence Perrymans Md.

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetry

DATE OF BURIAL Dec 24th, 1917

20-UNDERTAKER Madison Mitchell

ADDRESS Balto. Md

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11186 D11186

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Pierce St.; 17 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Murray

(Residence in Baltimore: No. 817 Pierce St.; 4 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S-t

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 4 8
.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andrew Murray

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Attie Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Murray

(Address) 817 Pierce St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1917, to Dec 22 1917, that I saw h alive on Dec 22 1917, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pyelo Nephritis

Chronic

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage of Kidney

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. Stewart M. D.

Dec 24, 1917 (Address) 939 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 24 1917

20-UNDERTAKER Brown & Richardson — ADDRESS 114 N. ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D11187

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Ettng ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louline Hill

(Residence in Baltimore: No. 1702 Etting st ST.: 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1873 (Year)

7-AGE. 44 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress 086
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hill

(Address) 1702 Etting st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 22d, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16th 1917, to Dec. 22d 1917, that I saw h— alive on Dec. 22d 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Tubercular Peritonitis

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) A. Lee Ellis M. D.

12/23, 1917 (Address) 924 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 25 1917

20-UNDERTAKER Jno A Haeland — ADDRESS 63 Druid Hill

DEC 24 1917 ROBERT R. CRAUTER DEPUTY REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11188

CERTIFICATE OF DEATH.

D11188

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Leigh

(Residence in Baltimore: No. 611 W Lexington St. St.; 5 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) ~~Single~~ Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1869 (Year)

7-AGE, 58 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 344
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Store 017

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) University Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 22 1917, that I saw h er alive on Dec 22 1917, and that death occurred, on the date stated above, at 7.55 A m.

The CAUSE OF DEATH* was as follows: Myocarditis Chronic Interstitial

(Duration) ..... yrs. ..... mos. 10 da.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) ..... M. D.

12/23, 191... (Address) Medical Dept.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 611 W Lexington St.

19-PLACE OF BURIAL OR REMOVAL, Wilmington Del — DATE OF BURIAL, 12/24, 191...

20-UNDERTAKER George A Tenny Sudlow & Fayette — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11189

CERTIFICATE OF DEATH.

D11189

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C 81

CITY OF BALTIMORE: (No. 10 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Ward

(Residence in Baltimore: No. Little Sisters of Poor St.; 2 yrs., 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1845 (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Coe

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Giselen

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 23d (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 191, to ..... 191, that I saw h~~e~~r alive on Dec 15 191 7, and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

..... Chronic Sclerosis

..... Unknown (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

Dec. 23, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Cathedral

DATE OF BURIAL, Dec. 26, 1917.

20-UNDERTAKER Wendell Ripple & Son

ADDRESS ~~North~~ 378 Conn

Emily Branson

D11190 HEALTH DEPARTMENT--CITY OF BALTIMORE D11190

CERTIFICATE OF DEATH

170

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. 576 Moore st. St.: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Branson

(Residence in Baltimore: No. 576 Moore st St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fem

4-COLOR OR RACE: Col

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Unknown (Month), (Day), 1852 (Year)

7-AGE: 65 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

877

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: Jno. Thomas

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Braun

(Address) 576 moore st

15

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 21 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1916, to, Dec. 21 1917, that I saw her alive on Dec. 20, 1917, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cebr. Arteriosclerosis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Carcinoma

(Duration) yrs. mos. ds.

(Signed), Dan'l Fundenburg M. D.

Dec. 23, 1917 (Address) 1005 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount auburn Cemetery

DATE OF BURIAL: Dec 24, 1917

20-UNDERTAKER: John H Toadvine

ADDRESS: 142 N Hill st

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

DEC 24 1917 ROBERT R. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D11191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11192

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 E. Pratt St ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Sherman

(Residence in Baltimore: No. 1518 E. Pratt St St.; 3 yrs., 2 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 1, 1914
(Month) (Day) (Year)

7-AGE, 3 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Sherman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kate Flax

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Sherman

(Address) 1518 E Pratt St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16 1917, to Dec. 24 1917, that I saw him alive on Dec. 23rd 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldberg M. D.

12-24, 1917. (Address) 2931 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rest Carmel

DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER Max Levinson

ADDRESS 1107 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11192

CERTIFICATE OF DEATH.

97 D11192

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1010 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Hunt

(Residence in Baltimore: No. 1010 Argyle Ave. St.; 24 yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 21 (Day), 1877 (Year)

7-AGE, 40 yrs. mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter 086
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Oscar Hunt

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Eva Ennis

(Address) 1010 Argyle Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 23 1917, that I saw him alive on Dec 22 1917, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows: Pneumonia & Colon

(Duration) .....yrs. .....mos. 23 ds.

CONTRIBUTORY (Secondary) C. S. Ennis M.D.

(Duration) .....yrs. .....mos. 21 ds.

(Signed) C. S. Ennis M. D.

Dec 23 191 7 (Address) 1010 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Peters Cem — DATE OF BURIAL, 12/26, 1917

20-UNDERTAKER Sam'l T Hunley — ADDRESS 578 N Bond

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D11193

CERTIFICATE OF DEATH.

91 D11193

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Pine ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie May Ferguson

(Residence in Baltimore: No. 423 N. Pine St.; — yrs., 2 mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, June 7th, 1917.
(Month) (Day) (Year)

7-AGE, — yrs. 6 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

500 665

9-BIRTHPLACE, (State or Country), Charleston S.C.

PARENTS.

10-NAME OF FATHER, Preston Robinson

11-BIRTHPLACE OF FATHER (State or Country), Charleston S.C.

12-MAIDEN NAME OF MOTHER Emmie Ferguson

13-BIRTHPLACE OF MOTHER (State or Country), Clinton S.C.

14-THE ABOVE IS ~~TRUE~~, TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmie Ferguson

(Address) 423 N. Pine St.

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 22d, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20th 1917, to Dec 22 1917, that I saw her alive on Dec 22 1917, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchial Pneumonia (Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Meningitis (Duration) — yrs. — mos. 3 ds.

(Signed) Edward E. Mackenzie M. D.

Dec 24, 191... (Address) 1329 W. Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cem	12/24 1917

20-UNDERTAKER Samuel J. Kennedy ADDRESS 578 N. Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

D11197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. C 92

CITY OF BALTIMORE: (No. Linden Ave & Madison ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME L. Frank Rock

(Residence in Baltimore: No. 2222 Walbrook Ave St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Nov 13, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, T. Hedley Rock

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary J Winstead

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles M. Rock

(Address) 2222 Walbrook Ave

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1917, to Dec. 23 1917, that I saw him alive on Dec. 23 1917, and that death occurred, on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) yrs. mos. ? ds.

(Signed) J. J. Roberts M. D.

12/23, 1917. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 3 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 2222 Walbrook Ave.

19-PLACE OF BURIAL OR REMOVAL. Sharps Richmond Co Va. (Lodge Vault)

DATE OF BURIAL, Dec 24, 1917

20-UNDERTAKER Armstrong & Denny Co

ADDRESS 715 Light St

DEC 24 1917 SOLLY E. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11195

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Montford Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Lind

(Residence in Baltimore: No. 716 N. Montford Ave St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 9 (Month), (Day), 1861 (Year)

7-AGE, 56 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anders Lind

(Address) 716 N. Montford Ave

15-

Filed....., 191.....

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month), 17 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 191 7, to Dec 20 191 7, that I saw h[illegible] alive on Dec 20 191 7, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edith Wellcott M. D.

....., 191 7. (Address) 716 N. Montford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 24, 191 7.

20-UNDERTAKER Christian Miller — ADDRESS 2334 Jefferson St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11196 HEALTH DEPARTMENT—CITY OF BALTIMORE D11196

CERTIFICATE OF DEATH.

89 ✓

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1911 Ramsey ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George O. Ford

(Residence in Baltimore: No. 1911 Ramsey St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Oct (Month) 31 (Day), 1891 (Year)

7-AGE: 36 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Meat Packer

9-BIRTHPLACE, (State or Country): Addison Md Maryland

PARENTS.

10-NAME OF FATHER: George O. Ford

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Susie Carr

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kate L. Ford

(Address) 1911 Ramsey

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Congestion of Lungs

(Duration) ....yrs. ....mos. 3 Hrs

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) James W. Lowdon M. D. (Coroner.)

Dec 24 191 7 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL, Dec 24, 19 17

20-UNDERTAKER: J. B. Cook — ADDRESS 1003 W. Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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Spec.—8-24-14—M. & T.—2000 Bks.

D11197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N. Charles ST.; 11 WARD)

REGISTERED NO. C

2-FULL NAME Emma Hoet Mortimer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. ...)

(Residence in Baltimore: No. 911 N. Charles St.; 4yrs. .. mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, or DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH. November (Month) ..., (Day) 1844 (Year)

7-AGE, 73 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ooo
(b) General nature of industry, business, or establishment in which employed (or employer). None ooo

9-BIRTHPLACE, (State or Country). Baltimore Balto Md

PARENTS.

10-NAME OF FATHER. Dan Holt

11-BIRTHPLACE OF FATHER (State or Country). Fairhaven Conn

12-MAIDEN NAME OF MOTHER. Anne Eve Seabold

13-BIRTHPLACE OF MOTHER (State or Country). New Berlin Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle Holt Bloodgood

(Address) 18 Midvale Rd Roland Park

15-

Filed ..., 191...

B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1917, to Dec 23 1917, that I saw h-e alive on Dec 23 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Nephritis - Arteriosclerosis

Sept 7-1917 Edema Volvulus Sigmoid

12-14-17 " Colostomy

(Duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Uremia

Sigmoid Post operation

(Duration) ... yrs. ... mos. 6 ds.

(Signed) Geo. C. Woodyard M. D.

12/23/1917. (Address) 904 N Charles St Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, 12-27..., 1917

20-UNDERTAKER H. Renkins Sons Co — ADDRESS Orchard Ine Calloway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 11198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 11198.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Myrtle ST.; 17 WARD)

REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John William Stevens

(Residence in Baltimore: No. 1235 Myrtle Ave St.; 60 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, August (Month) 20 (Day), 1835 (Year)

7-AGE, 82 yrs. 4 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Stevens

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louisa Massey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frances L. Stevens

(Address) 1235 Myrtle Ave

15-

Filed....., 191.....

....., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 23rd (Day), 1917. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1916, to Dec 22nd 1917, that I saw h[illegible] alive on Dec 22 1917, and that death occurred, on the date stated above, at ....a. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis, follows by Chronic nephritis & Dropsy, on the Supervening Disease (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Paralysis (Duration) 1 yrs. 5 mos. 10 ds.

(Signed) Wm. B. E. Deegan M. D.

Dec 23, 1917. (Address) 904 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Dec ....., 1917.

20-UNDERTAKER Stewart & Mowan Co

ADDRESS 106 W. North Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D-11199 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D-11199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 741 E.Fort Ave. St.: 24 WARD) 150

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle V.Roth.

(Residence in Baltimore: No. 741 E.Fort Ave. St.; yrs., 4 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, August 6th. 1917. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
...yrs. 4 mos. 17 ds.	...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jacob Roth.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Annie Lutsche.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Roth.(mother)
(Address) 741 E.Fort Ave.

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23rd. 1917. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary)
(Duration)...yrs...mos...ds.

(Signed) Chas. M. Reinhardt M. D.
(Coroner.)
Dec. 24th. 1917. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death...yrs...mos...ds. In the State...yrs...mos...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Dec 25, 1917
20-UNDERTAKER	ADDRESS
John F Tabler & Sons	1318 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 24 1917 ROBERT R. KRAUTER

D11200

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D11200

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4403 Garrison Boulevard St.; 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Birdie Jolenko

(Residence in Baltimore: No. 4403 Garrison Boulevard St.; 29 yrs. [illegible] mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: October (Month) 17 (Day), 1888 (Year)

7-AGE: 29 yrs. 2 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Social worker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Charleston W Va

PARENTS

10-NAME OF FATHER: Gustave Jolenko

11-BIRTHPLACE OF FATHER (State or country): Buda Pest

12-MAIDEN NAME OF MOTHER: Minnie Sabel

13-BIRTHPLACE OF MOTHER (State or country): Pressburg Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Jolenko

(Address) [illegible] Garrison Blvd

15

Filed DEC 24 1917, 191

ROBERT R. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th, 1917, to Dec 24 1917, that I saw h[illegible] alive on December 23, 1917, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. 6 mos. ds

Contributory (SECONDARY): Pleurisy

(Duration) yrs. mos. 14 ds.

(Signed) Hugh Pollock M. D.

Dec 24, 1917 (Address) 1112 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Har Sinai — DATE OF BURIAL: Dec. 25 1917

20-UNDERTAKER: Louis Sondheim — ADDRESS: [illegible]

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D11201

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noah Jordan

(Residence in Baltimore: No. 1523 Leslie St St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 16, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE (State or Country) Balto Maryland

PARENTS.

10-NAME OF FATHER, Noah Jordan

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lula Hudens

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1917 to Dec 20 1917, that I saw h alive on Dec 20 1917, and that death occurred, on the date stated above, at 10 15 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital Debility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Rivers M. D.

Dec 21, 1917. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1523 Leslie St

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Rivers DATE OF BURIAL, DEC 24 1917, 191...

20-UNDERTAKER Jas. H. Dennis ADDRESS 1303 Freeman St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11202

CERTIFICATE OF DEATH.

81 D11202

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin J Cleary

(Residence in Baltimore: No. 408 N. Mulberry St.; 7 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) ....., 1865 (Day) (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Saloon Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer) 043

9-BIRTHPLACE, (State or Country). Trenton N.J.

PARENTS.

10-NAME OF FATHER, Patrick Cleary

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Tully

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Cleary

(Address) 5408 Park Hts Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18th 1917, to Dec 24th 1917, that I saw him alive on Dec 24th 1917, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

I. Acute General Arteriosclerosis

(Duration) General yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnant Nonbelief - Hemorrhage -

(Duration) yrs. 4 mos. ds.

(Signed) J W. Keown M. D.

Dec 24, 1917. (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trenton N. J. DATE OF BURIAL, 12/25, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light

DEC 24 1917 ROBERT R. KRAUTER Registrar of Vital Statistics

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11203

CERTIFICATE OF DEATH.

67

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander George Kinnier

(Residence in Baltimore: No. 1737 Jefferson St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, February 3, 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(s) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Joseph Kinnear

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Eaton

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennette Kinnear

(Address) 1737 Jefferson St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1908, to Dec 24 1917, that I saw him alive on Dec 23 1917, and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia + Lacerated Pancreas

Pneumonia (Duration) 12 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 8 ds.

(Signed) C. P. Cannan M. D.

Dec 24, 1917. (Address) 1207 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Dec 26, 1917
20-UNDERTAKER Wm. Cook	ADDRESS 5032 Park

DEC 25 1917 ROBERT B. KRAUSER

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11204

CERTIFICATE OF DEATH.

92 V D11204

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 1/2 W. Lombard St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elise Pieper

(Residence in Baltimore: No. 824 1/2 W Lombard St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 22 (Day), 1872 (Year)

7-AGE, 45 yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gustav Pieper

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Augusta Eichman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav Pieper

(Address) 824 1/2 W. Lombard

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 22 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1917, to Dec. 22, 1917, that I saw h[illegible] alive on Dec. 22, 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec. 23, 191[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec. 25, 1917.

20-UNDERTAKER William Cook — ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1206 E Preston Hospital

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11205

CERTIFICATE OF DEATH.

15 D11205

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Thames ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Vulgaris

(Residence in Baltimore: No. 1722 Thames St.; — yrs., — mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Sing

6-DATE OF BIRTH, Dec 13, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
— yrs. — mos. 11 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, James Vulgaris

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Hattie Vulgaris

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr James Vulgaris

(Address) 1722 Thames St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 191.., to Dec 17 191.., that I saw h— alive on Dec 24 191.., and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(Duration)....yrs....mos. 13 ds.

CONTRIBUTORY (Secondary) Cedema Lungs

(Duration)....yrs....mos....ds.

(Signed) F. W. Scanlon M. D.

Dec 17, 191.. (Address) 16 S Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Dec 25, 1917.
20-UNDERTAKER	ADDRESS
Peter Nicolaus	2044 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D11206

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1453 Columbia Ave. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Traugott Frederick Aurich.

(Residence in Baltimore: No. 1453 Columbia Ave St.; 6 yrs., ... mos. ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, March (Month) 25 (Day), 1817 (Year)

7-AGE 100 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Farmer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna Riehl

(Address) 46 Garrison Lane

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1917, to Dec 22 1917, that I saw h[illegible] alive on Dec 22 1917, and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

.....

.....Senile Decay.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration).....yrs.....mos.....ds.

(Signed) Theresa F. Wahrenberg M. D.

....., 191... (Address) 508 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Leo A. Berberich

ADDRESS Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

D11207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11207

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Franklin Square Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Killian Huckman

(Residence in Baltimore: No. 2031 W. Baltimore St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 25 (Month), (Day), 1879 (Year)

7-AGE, 38 yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, W R Huckman

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Olivia Dupee

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lucy Huckman

(Address) 2031 W Balto St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23 (Month), (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4th 1917, to Dec 23 1917, that I saw h.. alive on Dec 23 1917, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

General Cachexia

(Duration) ....yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. .... mos. Don't know ds.

(Signed) Gilbert H. Montague M. D.

....., 191... (Address) 5201 Fullerton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 mos. 19 ds. In the State ....yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence 2031 W. Baltimore

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo. A. Gerber — ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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DEC 25 1917 ROBERT R. CRAWFORD REGISTRAR

Spec.—8-24-14—M. & T.—2000 Bks.

D11208 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D11208

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4004 Massachusetts Av. St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Margaret Watts

(Residence in Baltimore: No. 4004 Massachusetts Av St.; Cij yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Dec 16, 1917 (Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

800

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Henry Watts

11-BIRTHPLACE OF FATHER (State or Country), Howard Co

12-MAIDEN NAME OF MOTHER Mamie Gahagan

13-BIRTHPLACE OF MOTHER (State or Country), Norfolk Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Watts

(Address) 4004 Mass. Ave.

15-

Filed ....., 191.....

Registrar.

DEC 25 1917 ROBERT B. CHANLER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1917, to Dec 23 1917, that I saw h[illegible] alive on Dec 23 1917, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth of
Eight Months

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Howard W Jones M. D.

Dec 24, 1917. (Address) Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London PK Cem

DATE OF BURIAL, 12/25, 191.7

20-UNDERTAKER J. Fenwick McAnelly

ADDRESS 130 E. Fort.

Spec.—5-19-13—M. & T.—500 Bks.

D11209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68 ✓ D11209

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 S Paca ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Emmeman

(Residence in Baltimore: No. 628 S Paca St St.; ..... yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1856 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day. ..... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Ferdinand Emmeman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Clara Hilgeheimer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Emmeman

(Address) 628 S. Paca st.

15-

DEC 25 1917 ROBERT P. KRAUTER

Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1917, to Dec 22 1917, that I saw h[illegible] alive on Dec 22 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Menancholia

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ..... yrs. Am mos. ..... ds.

(Signed) S. M. Lamperton M. D.

....., 191... (Address) 826 N. Arrusted Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Most Holy Redeemer

DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER F. A. Krause

ADDRESS 703 S Howard

Spec.—8-24-14—M. & T.—2000 Bks.

D11210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X81 ✓ D11210

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick George Clarke

(Residence in Baltimore: No. Johns Hopkins Hosp. St.; ..... yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) married

6-DATE OF BIRTH, ... Aug. (Month) 7 (Day) 1863 (Year)

7-AGE, 54 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Manufacturer 45
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Tailor

9-BIRTHPLACE, (State or Country), Peterboro, Ont. Canada

PARENTS.

10-NAME OF FATHER, John Clarke

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Russell

13-BIRTHPLACE OF MOTHER (State or Country), St. Andrews Scot.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Clarke

(Address) Toronto Canada

15-

Filed ....., 191.....

Registrar.

DEC 25 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 25 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 21 1917, to Dec 25 191., that I saw h— alive on Dec. 24, 1917., and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

..... (Duration) Undetermined yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) 11 yrs. — mos. 11 ds.

(Signed) S. E. [illegible] M. D.

Dec 25 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death X yrs. X mos. 11 ds. In the State X yrs. X mos. 18 ds.

Where was disease contracted, if not at place of death? At home in

Former or usual residence Toronto, Canada

19-PLACE OF BURIAL OR REMOVAL, Toronto Canada

DATE OF BURIAL, Dec. 25., 1917.

20-UNDERTAKER Albert E. Fuller

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11211

CERTIFICATE OF DEATH.

92 D11211

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 N Pearl ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Liberto

(Residence in Baltimore: No. 308 N Pearl St ward 30 St.; .....yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, ... June ....., 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Fruit Vendor
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Vendor D45

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Vincent Liberto

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Faina Giardino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... James Liberto

(Address) ..... 308 N Pearl St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 23 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1917, to Dec 23 1917, that I saw h[illegible] alive on Dec 23 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia HW

..... (Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation, Edema of Lungs (Duration) .....yrs. .....mos. 1 ds.

(Signed) ..... Jos. J. Chisholm M. D.

Dec 24 1917. (Address) 516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER Lee J. Rutt ADDRESS 1135 Buford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11212

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

56 D11212

REGISTERED NO. C

CITY OF BALTIMORE: (No. University Hosp ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kleinschmidt

(Residence in Baltimore: No. 316 Hanover St ST.; 22 yrs., mos. da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. 1880 (Month) (Day) 1 (Year)

7-AGE. 37 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 902

(a) Trade, profession, or particular kind of work. Bartender

(b) General nature of industry, business, or establishment in which employed (or employer). 044

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Kleinschmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Wahrhem

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Rosenkemper

(Address) 316 Hanover St.

15-

DEC 23 1917 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24 (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18 1917, to Dec 24 1917, that I saw h... alive on Dec. 24 1917, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Delirium tremens

(Duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Harry M. Stein M. D.

Dec. 24, 1917. (Address) Univ. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem.	Dec. 26, 1917.
20-UNDERTAKER Chas. H. Dill.	ADDRESS 3187 Greed K. Ave.

Form 8-24-14—M. & T.—2000 Blks.

D11213 Virginia Darrell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11213

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Hanover St. 23 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Darrell

(Residence in Baltimore: No. 1325 Hanover St.; 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 15, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ———
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Arthur Darrell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Virginia Spedden

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Virginia Darrell

(Address) 1325 Hanover St

15-

Filed....., 191.....

Registrar.

DEC 25 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 25 1917, that I saw her alive on Dec 24 1917, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Congenital weakness due to premature birth - 7 mos gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Same

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm E Lightner M. D.

12/25, 1917. (Address) 131 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec. 26, 1917.

20-UNDERTAKER Wm J. Leonard & Son

ADDRESS 1428 N. Charles

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11214 HEALTH DEPARTMENT—CITY OF BALTIMORE D11214

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Devins

(Residence in Baltimore: No. 2433 E Monument St.; 55 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, September 9, 1 (Month) (Day) (Year)

7-AGE, 72 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchmaker
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Wm Devins

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Devins

(Address) 2433 E. Monument St.

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1917, to Dec 23 1917, that I saw h.m alive on Dec 22 191..., and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Myocarditis

..... (Duration) ... yrs. 6 mos. ... ds.

(Signed) Adam E Bauman M. D.

Dec 24, 191... (Address) 18 N Holliday St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. U. S. National Cemetery

DATE OF BURIAL, Dec 26, 191...

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11215 HEALTH DEPARTMENT—CITY OF BALTIMORE 150 D11215

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3426 Auchentoroly St.; 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen Jacobs

(Residence in Baltimore: No. 3426 Auchentoroly St.; yrs., 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 16 (Day), 1917 (Year)

7-AGE. ....yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (—)
(b) General nature of industry, business, or establishment in which employed (or employer) (—)

9-BIRTHPLACE, (State or Country), Balto city Md

PARENTS.

10-NAME OF FATHER, Herman Jacobs

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Famie Treiger

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....(Duration).....yrs.....mos.....ds.

(Signed) J. Louis Morrison M. D.
(Coroner.)
Dec 26 191.. (Address) 632 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew	12-5, 1917
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11216

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 S. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Jane Nichols

(Residence in Baltimore: No. 102 S. Chapel St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Jan (Month) 10 (Day), 1850 (Year)

7-AGE, 67 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Samuel Richards

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Jefferson

(Address) 710 W. Wolfe St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5 1917, to Dec 24 1917, that I saw h alive on Dec 22 1917, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uraemia

(Duration) ....yrs. 8 mos. 9 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) G. G. Thom M. D.

Dec 24 1917. (Address) Chas. & Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem

DATE OF BURIAL, Dec. 27, 1917

20-UNDERTAKER Jos. J. Burns 1606 N.

ADDRESS Linganore

Spec.—8-24-14—M. & T.—2000 Bks.

D11217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp St.; ..... WARD) 79 REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah Mayer

(Residence in Baltimore: No. 322 Park ave St.; 80 yrs., 4 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 21st, 1837
(Month) (Day) (Year)

7-AGE, 80 yrs. 4 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frederick Mayer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Dietz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Broeder

(Address) 2411 Linden Ave

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1917, to Dec 23 1917, that I saw h[illegible] alive on Dec 23 1917, and that death occurred, on the date stated above, at 11 48 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bernard Jacobson M. D.

Dec 23, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 322 Park Ave

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec 26th, 1917.

20-UNDERTAKER Mr & Mrs John H Seufert

ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11218

CERTIFICATE OF DEATH.

D11218

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard W. Shield

(Residence in Baltimore: No. 1803 10th St (Walbrook) St.; 14 yrs.. — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, 18 Feb. 25 (Month) (Day) 1848 (Year)

7-AGE, 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Saml K. Shield

11-BIRTHPLACE OF FATHER (State or Country) Accomac Co Va

12-MAIDEN NAME OF MOTHER Mary J Ames

13-BIRTHPLACE OF MOTHER (State or Country), Accomac Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Brocato

(Address) 728 Poplar Grove St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 25th (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1917, to Dec. 25 1917, that I saw him alive on Dec. 25. 1917, and that death occurred, on the date stated above, at 11 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) 5 yrs. — mos. 5 ds.

(Signed) Hurley M. D.

12/25, 191.. (Address) Mercy St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1803 10th St. Walbrook

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, 12/27, 191.7

20-UNDERTAKER Robert Brockerson

ADDRESS Calhoun Hollins Sts

Scholl

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1219

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1725 Baker ST.: 15 WARD)

2-FULL NAME Lewis L. Scholl

(Residence in Baltimore: No. 1725 Baker.

St.; 49 yrs., mos. ds.)

19 D1219

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 50

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. May (Month) 23, (Day) 1869, (Year)

7-AGE, 48 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Automobile
(b) General nature of industry, business, or establishment in which employed (or employer). Owner

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, L C Scholl

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Louisa Wade

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brother

(Address) 1725 Baker

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec (Month) 28 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Disseminated Tuberculosis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged Thymus

Duration yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

Dec 28, 191 (Address) Myrtle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rockville Md. DATE OF BURIAL, Dec 31st, 19 17

20-UNDERTAKER Penny & Mo ADDRESS F B Hilpert 223 Frederick Av

D11230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15½ D11230

REGISTERED No. C

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 727 N Chester ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Ritter

(Residence in Baltimore: No. 727 N Chester St.; yrs 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1917 (Year)

7-AGE, 9 years ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Ritter

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Annie Lloyd

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Ritter

(Address) 727 N Chester

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Dec ..., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Dec 26 1917

20-UNDERTAKER J Herwig & C

ADDRESS 2008 Aliceanna St.

DEC 6 1917 ROBERT B. KRAUTER

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

D11221

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D11221

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. ..... St.: 7 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME .....

(Residence in Baltimore: No. ..... St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ale

4 COLOR OR RACE: hite

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)

6 DATE OF BIRTH: Mch 23, 1867 (Month) (Day) (Year)

7 AGE: 50 yrs. 9 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Music Teacher and
(b) General nature of industry, business, or establishment in which employed (or employer): Organist

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Frank

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nettie H Frank
(Address) 304 N. Fulton Ave

15 .....

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ..... (Month) ..... (Day) , 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191 , to ....., 191 , that I saw h alive on ....., 191 , and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed), ... M. D.

....., 191 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn DATE OF BURIAL: Dec 28, 1917

20 UNDERTAKER: Jos B Cook ADDRESS: 1003 W Balto

Spec.—5-19-13—M. & T.—500 Bks.

D11222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 W. Lombard ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Ann Pierpoint

(Residence in Baltimore: No. 902 W Lombard St.: 82 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. May 29, 1835 (Month) (Day) (Year)

7-AGE, 82 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Caroline Co. Md.

PARENTS.

10-NAME OF FATHER, James Sullivan

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. H. Pierpoint

(Address) 902 W. Lombard St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1915 1915, to Dec 24 1917, that I saw h[illegible] alive on Dec 24 1917, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Clinical

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. ds.

(Signed) Joseph E. Muse M. D.

Dec 26, 1917 (Address) 1320 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER Jos Block — ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11223 HEALTH DEPARTMENT--CITY OF BALTIMORE 50 D11223

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1017 W. Lanvale ST. 16 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Moses C. Hodgdon

(Residence in Baltimore: No. 1017 W. Lanvale St. 45 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: March 5, 1842 (Month) (Day) (Year)

7 AGE: 75 yrs. 9 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Broker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9 BIRTHPLACE (State or country): New Hampshire

PARENTS

10 NAME OF FATHER: Ebenezer Hodgdon

11 BIRTHPLACE OF FATHER (State or country): New Hampshire

12 MAIDEN NAME OF MOTHER: Copp

13 BIRTHPLACE OF MOTHER (State or country): New Hampshire

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Getz, M.D.

(Address) 1111 W. Lanvale St

15

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 24, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1917, to Dec 24 1917, that I saw him alive on Dec 24, 1917, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Diabetes Mellitus

(Duration) 4 yrs. — mos. — ds.

(Signed) Charles Getz M. D.

Dec 25, 1917 (Address) 1111 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount? DATE OF BURIAL: Dec. 26, 1917

20 UNDERTAKER: John O. Mitchell ADDRESS: Rec'd. Payette

DEC 26 1917 ROBERT B. KRAUTZ

Spec.—8-24-14—M. & T.—2000 lbs.

D11224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D11224

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 West Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Armiger Johnson

(Residence in Baltimore: No. 1830 West Mosher St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct. 9, 1877.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
40 yrs. 2 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer) House wife

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Geo. H. Crane.

11-BIRTHPLACE OF FATHER (State or Country), A. A Co Md.

12-MAIDEN NAME OF MOTHER Anna S. Rew.

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence S. Johnson

(Address) 1830 W. Mosher St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Dec. 24 1917, that I saw h[illegible] alive on Dec 23 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown. (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General debility

Unknown. (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. C. Conser M. D.

12-26, 1917. (Address) 1101 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Dec. 26, 1917.

20-UNDERTAKER	ADDRESS
Chas. Mitchell	120 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

D11225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11225

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH
CITY OF BALTIMORE (No. City Jail ST.: 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Schumacher

(Residence in Baltimore: No. 2336 Riverstown Road St.: yrs., 50 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Sept 23 1857
(Month) (Day) (Year)

7-AGE. 60 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Henry Schumacher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mari Schmoele

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Schumacher

(Address) 2336 Riverstown

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Straus M. D.
(Coroner.)

Dec 25, 1917. (Address) 16 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Dec 26 1917.

20-UNDERTAKER W M Roulson

ADDRESS 230 N Green

Spec.—8-24-14—M. & T.—2000 Bks.

D11226 HEALTH DEPARTMENT—CITY OF BALTIMORE D11226

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 672 W Lexington ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Stent

(Residence in Baltimore: No. 672 W Lexington St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Aug (Month) 6th (Day), 1851. (Year)

7-AGE, 66 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, J. H Hausddaffer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. H Hausch

(Address) 762 W Lexington

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1917, to Dec 25th 1917, that I saw h er alive on Dec 25th 1917, and that death occurred, on the date stated above, at 8.45A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

(Signed) J Emory Poulton M. D.

Dec 25, 1917. (Address) 654 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Dec 27, 1917.

20-UNDERTAKER N M Routzon

ADDRESS 230 N Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11227

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Fairview Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Thayer

(Residence in Baltimore: No. 3603 Fairview Ave St.; ..... yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word.) Widow

6-DATE OF BIRTH, May 16, 1831 (Month) (Day) (Year)

7-AGE, 86 yrs. 7 mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Mass

PARENTS.

10-NAME OF FATHER, Summer Pierce

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Elyza Gorham

13-BIRTHPLACE OF MOTHER (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Fred H. Thayer

(Address) 3603 Fairview Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to Dec 25 1917, that I saw her alive on ..... 191....., and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred H. Thayer M. D.

....., 191... (Address) 514 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Shethrygan Wise — DATE OF BURIAL, Dec 26 1917

20-UNDERTAKER Geo A Gerberg — ADDRESS Baltimore Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Denis K. Toohey

D11228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11228

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 S. Eutaw ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Denis K Toohey

(Residence in Baltimore: No. 227 S. Eutaw St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec (Month) 23 (Day) 1856 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. mos. 1 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist Helper
(b) General nature of industry, business, or estsblishment in which employed (or employer): B & O

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informsnt) Mrs Kate Toohey

(Address) 227 S Catherine st

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1912, to Dec 24 1912, that I saw him alive on Dec 24 1912, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) D. C. Barnes M. D.

Dec 24, 1912 (Address) 1302 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 26, 1912

20-UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11229

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

Registered No. C

CITY OF BALTIMORE (No. 2448 Maryland Ave St.: 12 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emma A. Kinsey

(Residence in Baltimore: No. 2448 Maryland Ave St.: N yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: February (Month) 8 (Day), 1834 (Year)

7 AGE: 83 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Pa.

PARENTS

10 NAME OF FATHER: Thomas Smyth

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Shayler

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josiah Kinsey

(Address) 1210 N. Eutaw St.

15.

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1917, to Dec. 24 1917, that I saw her alive on Dec. 23, 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Geo. H. Stone M. D.

....., 191.... (Address) 2430 N. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: LOUDON PARK. DATE OF BURIAL: DEC 26 1917

20 UNDERTAKER: ARMSTRONG-DENNY CO. ADDRESS: 715 Light St

D11230

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 D11230

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospital St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adina M. Murphy

(Residence in Baltimore: No. 2313 N. Calvert St.; yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH ~~~

Spec.—8-24-14—M. & T.—2000 Bks.

D11231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D11231

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 N. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J Henry Hoffman

(Residence in Baltimore: No. 1017 N. Dallas St.; 55 yrs., 2 mos. 14 ds.)

N.B.—Entries on this certificate should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October (Month) 10 (Day) 1862 (Year)

7-AGE, 55 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor in
(b) General nature of industry, business, or establishment in which employed (or employer): Cement & Paving

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER. John P. Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Pool

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mollie Hoffman

(Address) 1017 N. Dallas St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Dec~~ Dec. 24 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17 1917, to Dec. 24 1917, that I saw h in alive on Dec. 23 1917, and that death occurred, on the date stated above, at 5 55 m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Lobar

Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Wm J Schmitt M. D.

Dec 24, 1917. (Address) 701 N Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemy

DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER Henry Hoerle Sons

ADDRESS 1301 E. Eager St

D11232

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D11232

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1911 W Lafayette ave STR. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F Germershausen

(Residence in Baltimore: No. 1911 W Lafayette ave ~~or~~ 65 yrs. 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: May (Month) 29th (Day) 1852 (Year)

7-AGE: 65 yrs. 3 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Frederick Whitehead

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary Gantrum

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Germershausen

(Address) 1911 W Lafayette ave

15- .....

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 22nd (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8th, 1915, to Dec 22 1917, that I saw her alive on Dec 21st, 1917, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstetial

(Duration) 3 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Ken Williams M. D.

Dec 22, 1917. (Address) 601 Cumberland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Dec 26, 1917

20-UNDERTAKER: M. J. Flynn

ADDRESS: 1422 Light

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS CERTIFICATE MUST BE WRITTEN WITH PERMANENT BLACK INK. THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Hanover St.; 23 WARD)

REGISTERED NO. C 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Norton

(Residence in Baltimore: No. 1304 Hanover St.; ..... yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, Dont Know ..... (Month) ....., 1 ..... (Day) ....., ... (Year)

7-AGE, 86 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Govans. Md.

PARENTS.

10-NAME OF FATHER, Thos. Wilson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Mooney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. Norton

(Address) 35 W. West St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23 (Month) ....., (Day) ....., 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 23 1917, that I saw her alive on Dec 23 1917, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cystitis nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Thos Miller M. D.

Dec 26, 1917. (Address) 1022 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys (Govans) DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light St.

DEC 26 1917 ROBERT E. RAUCH
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11231

CERTIFICATE OF DEATH.

D11231

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 n Port ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilmer Otis Bowen.

(Residence in Baltimore: No. 1307 n Port St St.; ..yrs.,..mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Nov 25, 1917
(Month) (Day) (Year)

7-AGE, ..yrs. 1 mos. ..ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, W. J Bowen

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Anna L. Berrie

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilmer Bowen

(Address) 1307 N Port St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 24 1917, that I saw h m alive on Dec 24 1917, and that death occurred, on the date stated above, at 5a. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

..... (Duration)..yrs..mos. 1 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)..yrs..mos..ds.

(Signed) D P Herzog M.D. M. D.

Dec 25, 1917 (Address) 130 S Port St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem

DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER Leo. G. Crook

ADDRESS North Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11235

HEALTH DEPARTMENT--CITY OF BALTIMORE

D11235

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 50

CITY OF BALTIMORE (No. 1808 Bolton St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte E Groom

(Residence in Baltimore: No. 1808 Bolton St. St.; 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb 25, 1860 (Month) (Day) (Year)

7-AGE: 57 yrs. mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Iron 37
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Talbot Co Md

PARENTS

10-NAME OF FATHER: Solomon Coburn

11-BIRTHPLACE OF FATHER (State or country): Trappe Talbot Co Md

12-MAIDEN NAME OF MOTHER: Rebecca Blake

13-BIRTHPLACE OF MOTHER (State or country): St Michaels Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Marston J. Krebs

(Address) 1609 Madison Av

15

Filed ....., 191.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1917, to Dec 24 1917, that I saw h[illegible] alive on Dec 24, 1917, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Diabetes followed by Diabetic Coma

6 (Duration) yrs. 6 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Chas E. Sadler M. D.

Dec 25, 1917 (Address) 1445 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Dec 27, 1917

20-UNDERTAKER: George F. Smith

ADDRESS: 1000 Fayette E

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11236

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Bevans ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reuben Treat

(Residence in Baltimore: No. 802 Bevans St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Apl. (Month) ..... (Day) 1884 (Year)

7-AGE. 33 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Reuben Treat

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Jane Sparks

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Talbott

(Address) 802 Bevans St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at 4.00 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. C. Jones M. D.

....., 191... (Address) Tappahannock

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Essex Co. Va

DATE OF BURIAL. Dec 27..., 1917.

20-UNDERTAKER L. L. Brown & Son

ADDRESS 438 W. Monty St

Ladens Wf. Rappahannock River route

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11237 HEALTH DEPARTMENT—CITY OF BALTIMORE D11237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 N. Amity St.: 18 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Barnes

(Residence in Baltimore: No. 12 N Amity St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col.	Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Barnes

(Address) 12 N Amity St

15-

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. L. Driscoll M. D.
(Coroner.)

Dec 23, 1917. (Address) 121 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Old Auburn	....., 19....
20-UNDERTAKER Bennett Freeland & Schroder	ADDRESS 114 N

Spec.—8-24-14—M. & T.—2000 Blks.

D11238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C .....

CITY OF BALTIMORE: (No. ..... ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Howard

(Residence in Baltimore: No. Little Sisters of the Poor St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 25, 1874
(Month) (Day) (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Glen Howard

12-MAIDEN NAME OF MOTHER M. Joffney

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 23d, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to ..... 191..., that I saw h[illegible] alive on Dec 15 1917, and that death occurred, on the date stated above, at 3:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Contributory

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Warren M. D.

Dec 23, 1917. (Address) 1130 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 15 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, Dec 26/1917

20-UNDERTAKER H. C. Wedefeld & Bro — ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D11239

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 3448 Roland Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Kenneth Bond

(Residence in Baltimore: No. 3448 Roland ave St.; 9/0 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July 8 (Month), (Day), 1917 (Year)

7-AGE, ... yrs. 5 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt Maryland

PARENTS.

10-NAME OF FATHER, George K. Bond

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, May Stouffer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. K. Bond

(Address) 3448 Roland Av

15-

Filed ....., 191.....

..... Registrar.

DEC 26 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/23 191 7, to 12/24 191 7, that I saw him alive on 12/24 191 7, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

Convulsions

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Grover Dexter M. D.

....., 191... (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet C. N.	Dec 29 191
20-UNDERTAKER	ADDRESS
D Marshall	2537 Pitts Rd

D11240

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D11240

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 618 W. 33rd St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna P. McSpurren

(Residence in Baltimore: No. 618 W. 33rd St.: yrs. 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: April 26, 1899 (Month) (Day) (Year)

7-AGE: 18 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill Hand
(b) General nature of industry, business, or establishment in which employed (or employer): 463 046

9-BIRTHPLACE (State or Country): Balto Co

PARENTS.

10-NAME OF FATHER: Wm McSpurren

11-BIRTHPLACE OF FATHER (State or Country): Carroll Co

12-MAIDEN NAME OF MOTHER: Nellie M Marsh

13-BIRTHPLACE OF MOTHER (State or Country): Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm McSpurren

(Address) 618 W. 33rd St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

Autopsy

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) H. Augustus Morrison M. D. (Coroner.)

Dec 29 1917. (Address) 3632 Riverside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Place of usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet DATE OF BURIAL, Dec 27 1917

20-UNDERTAKER: H S Wachsmuth ADDRESS: 1359 Fell Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11211

D11211

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 W. 28th St. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burnett Whittington

(Residence in Baltimore: No. 404 W. 28th St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 11 (Day), 1880 (Year)

7-AGE, 37 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Weaver
(b) General nature of industry, business, or establishment in which employed (or employer): Cotton Mills

9-BIRTHPLACE, (State or Country), W. Va

PARENTS.

10-NAME OF FATHER, John N. Whittington

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Celestine Gallaher

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Celestine Whittington

(Address) 404 W 28th

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23 1917, to Dec 25 1917, that I saw h alive on Dec 25 1917, and that death occurred, on the date stated above, at 10.0 P m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(b) Influenza

(c)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ....yrs. 3 mos. ....ds.

(Signed) E A Rich M. D.

Dec 26, 191 7 (Address) 112 W 25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 27, 191 7

20-UNDERTAKER A S Marshall — ADDRESS 510 Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11212

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 E. Fountain St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Louise Grace

(Residence in Baltimore: No. 202 E. Fountain St.; 12 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Nov 25 1865
(Month) (Day) (Year)

7-AGE, 52 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... home

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, Wm Thomas Lemmon

11-BIRTHPLACE OF FATHER (State or Country), Fredrick Co.

12-MAIDEN NAME OF MOTHER Sarah Jane

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo M. Grace

(Address) 202 E. Fountain St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 25 1917, that I saw her alive on Dec 24 1917, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191.. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec 26 1917
20-UNDERTAKER	ADDRESS
W J Tuckner	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D11213

REGISTERED No. C.....

1-PLACE OF DEATH Md Gen. Hosp.

CITY OF BALTIMORE: (No. Loudon & Madison ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Nicholson

(Residence in Baltimore: No. Harmon Station St.; 50 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Black.	Married

6-DATE OF BIRTH. October ?, 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
50 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Rail road.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benj. H. Nicholson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... E. Owens

(Address)..... 425 W Camden

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1917, to Dec 24 1917, that I saw h[illegible] alive on Dec 24 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Streptococcus Infection

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Railroad Accident

..... (Duration) yrs. mos. 4 7 ds.

(Signed)..... H O Robertson M. D.

12-24..., 1917. (Address) Old Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 7 ds. In the State 50 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lambert Cem. Inc	Dec 27, 1917.

20-UNDERTAKER	ADDRESS
W J Tuckerman	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11211

CERTIFICATE OF DEATH.

92 D11214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Beck

(Residence in Baltimore: No. 1401 N. Caroline St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Lee Beck

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Barbara Fahman

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Beck

(Address) 92 Columbia Ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1917, to Dec 23 1917, that I saw her alive on Dec 23 1917, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Bernard S. Jacobson M. D.

Dec 23, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 hrs in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1401 N Caroline St

19-PLACE OF BURIAL OR REMOVAL, Westview

DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER W. F. Uhlmeyer

ADDRESS Pimlico Md

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11215

D11215

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home + Infir... ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh McD Spiers

(Residence in Baltimore: No. 19 Day's St.; ... yrs., ... mos. 19 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state information about of carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month) Aug. (Day) 8, (Year) 1848.

7-AGE, 69 yrs. 4 mos. 17 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Wm B. Spiers

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Maryand Reny

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Spiers

(Address) Loma N. C.

15-

Filed ..., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1917, to Dec 25 1917, that I saw h[illegible] alive on Dec 25 1917, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Hypostasis with Edema of Lungs

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ... yrs. ... mos. 4 ds.

(Signed) ... M. D.

Dec 26, 1917 (Address) Church Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 19 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Loma N. C.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Franklin Va	Dec 26 1917.
20-UNDERTAKER Gilbert E Fuller	ADDRESS 221 N Bruby

Spec.—8-24-14—M. & T.—2000 Bks.

D11246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11246

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 N Rutland ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Bartman

(Residence in Baltimore: No. 1619 N Rutland St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feby 17, 1893
(Month) (Day) (Year)

7-AGE, 24 yrs. 10 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER Wm F Bartman

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Mary F Broten

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F Broten

(Address) 1619 Rutland

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 191..., to Dec 24 1917, that I saw him alive on Dec 24 1917, and that death occurred, on the date stated above, at 12.10 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

(Signed) R G Dawes M. D.

....., 191... (Address) 1619 N Rutland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cemetery	Dec. 27, 1917
20-UNDERTAKER	ADDRESS
Albert E. Fuller	201 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D11247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 N. Carlin St 6 ST.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bailey Rochman

(Residence in Baltimore: No. 35 N. Carlin St St.; 6 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown ....., 18..
(Month) (Day) (Year)

7-AGE, 77 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ood

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Abraham

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Annie Hoffil

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balt St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1917, to Dec 25 1917, that I saw her alive on Dec 25 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) M. Taylor M. D.

Dec 27, 191.. (Address) 217 Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herman	12/28, 191.7
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1121S

CERTIFICATE OF DEATH.

15 D1121S

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Kartter

(Residence in Baltimore: No. 1815 N. Charles St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	

6-DATE OF BIRTH. Dec. ~~25~~ (Month) 25 (Day), 1917. (Year)

7-AGE, 20 minutes ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER. Kenzie H. Kettler

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Gladys C. Passano

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kenzie H. Kettler

(Address) 1815 N. Charles St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25 (Month) (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 , to ..... 191 , that I saw h alive on Dec 25 191 , and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Mens. weeks prematurity

Fed. Mfg. & Infan. Mortality

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John M. T. Bayland M. D.

Dec 26, 1917. (Address) 4 W. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Dec 26, 1917.

20-UNDERTAKER Wm. Cook. ADDRESS 502 E. 40th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11219

CERTIFICATE OF DEATH.

120 D11219

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 E 28 ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Jackson

(Residence in Baltimore: No. 1911 E 28th Street St.; 3 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 13, 1878 (Month) (Day) (Year)

7-AGE, 39 yrs. — mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Barber
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper Oyster House

9-BIRTHPLACE, (State or Country), Balto Co.

PARENTS.

10-NAME OF FATHER, Jessie Jackson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Susan Ulysses

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Susan Jackson.....

(Address) 1911 E 28 St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 24 1917, that I saw him alive on Dec 24 1917, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) Jno W Morrison M. D.

Dec 26 1917. (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Dec 28, 1917

20-UNDERTAKER William Cook — ADDRESS 502 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11250

CERTIFICATE OF DEATH.

102

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Severn Apartments, Cathedral ST.; 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Handy Collins Vickers

(Residence in Baltimore: No. Severn Apartments, Cathedral St.: 72 yrs., 10 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, December (Month) 17 (Day) 1845 (Year)

7-AGE, 72 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Capitalist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, George R. Vickers

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth W. Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel R. Vickers

(Address) Belvedere Hotel

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 25th (Day), 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15th 1917, to December 25th 1917, that I saw him alive on December 25th 1917, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration; excessive dilatation; oedema of lungs.

Acute attack..... (Duration) ..., ... yrs. ..... mos. 11 ds.
Chronic .....
CONTRIBUTORY (Secondary) Gastric Ulcer; Probably the focus of infection (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Thomas L. Shearer M. D.

Dec. 26th 1917. (Address) 905 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	12-27..., 1917.
20-UNDERTAKER	ADDRESS
Henderson Bros	McCulloh & Eutaw

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11251

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D11251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 Light ST.; 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Strodtman

(Residence in Baltimore: No. 1842 Light St. St.; 57 yrs., ... mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 25 (Day), 1860 (Year)

7-AGE, 57 yrs. ..... mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Strodtman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Shultz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lanahan

(Address) Light St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16th 1917, to Dec 24th 1917, that I saw h.. alive on Dec 23d 1917, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec 26, 1917 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem. DATE OF BURIAL, Dec 26, 1917

20-UNDERTAKER M. J. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11252

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Bond ST.; 2 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaw Godzinski

(Residence in Baltimore: No. 619 S. Bond St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1889 (Year)

7-AGE, 28 yrs. 11 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Russian Poland

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leokadya Godzinska

(Address) 619 S. Bond

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23 1917, to Dec. 24 1917, that I saw h— alive on Dec. 24 1917, and that death occurred, on the date stated above, at 5P. m.

The CAUSE OF DEATH* was as follows:

Acute Colic
due to Intestinal Obstruction,

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John A. Kelbergen M. D.

Dec. 25, 1917. (Address) 110 Gallatin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Dec 26 191 7
20-UNDERTAKER William Fiegenbaum	ADDRESS 1611 E. Eutaw ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11253 HEALTH DEPARTMENT—CITY OF BALTIMORE D11253

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3311 Barkley ST.: W. WARD)

2-FULL NAME Fr-P. Malden

(Residence in Baltimore: No. 3311 Barkley St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE,

.....yrs. 8 mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

..... Pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) H. Hunt Morrison M. D.
(Coroner.)

Dec 24 1917 (Address) 7232 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, DEC 27 1917, 19....

20-UNDERTAKER CHARLES H. DENNIS ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11251 HEALTH DEPARTMENT—CITY OF BALTIMORE D11251

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. Ball

(Residence in Baltimore: No. 1346 Argyle ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto -

PARENTS.

10-NAME OF FATHER, Eli Ball

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Kate Ruleh

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ball

(Address) 1346 ~~Argyle~~ Argyle

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Burns
Caused by paper burning - accidental
(Habit of putting paper in stove) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
....., 191... (Address) 163 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death about 2 weeks yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Dec 29 1917

20-UNDERTAKER James H Davis ADDRESS 1309 Reed St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D11255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11255

CERTIFICATE OF DEATH.

169

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1018 nc Donald St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Braun.

(Residence in Baltimore: No. 1018 nc Donald St.; yrs., 52 mos. ds.)

Mc Donough

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md. Balto

PARENTS.

10-NAME OF FATHER, Morgan Braun

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Shreve

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Snyder (daughter)

(Address) 1018 Mc Donough St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 26 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Manslaughter asphyxia by [illegible]

1018 nc Donald St (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D. (Coroner.)

Dec 27, 191 7. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Dec 29, 1917.

20-UNDERTAKER Mrs. A Rohde & Son

ADDRESS 730 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 26 1917 ROBERT P. BRAUER

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Latimer / Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11256

CERTIFICATE OF DEATH.

64 ✓ D11256

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1618 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara K Farber

(Residence in Baltimore: No. 1618 Holbrook St.; 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, June, 1861
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Gotlum

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Barbara Flahrwald

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bradley

(Address) 1618 Holbrook St

15-

Filed.....; 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26th, 1917.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH* was as follows:

High Blood Pressure
Contributory Myocarditis
(Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) 4 yrs. 11 mos. ds.

(Signed) Edward C. Eckert M. D.

Dec. 26, 191 7 (Address) 1419 Edgar St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER Thos. J. Kane & Sons ADDRESS 608 Lafayette Ave

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lks.

D11257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1175 E. Lombard ST.; 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Clark

(Residence in Baltimore: No. 1175 E. Lombard St.; five yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 28 (Day), 1862 (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 7 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Clark

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Clark

(Address) 1175 E. Lomabrd.

15-

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1917, to Dec 26 1917, that I saw ... alive on Dec 25 1917, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease
and Uremic Poisoning

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 26 1917 (Address) 6 W. Mt. Vernon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: St Vincents Cem. DATE OF BURIAL: 12/28/1917

20-UNDERTAKER Chas. F. Evans & Son ADDRESS 1180 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11258

CERTIFICATE OF DEATH.

169 D11258

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Homer & Guilford Ave Darley Hotel ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. W. Ulmer

(Residence in Baltimore: No. Darley Hotel Homer & Guilford Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Carpenter (b) General nature of industry, business, or establishment in which employed (or employer). 015

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Eustace Calvert Slater

(Address) Broad & Lanvale Baltimore

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 15, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation by unbalanced illuminating gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas Ryan Dunn M. D.

(Coroner)

Dec 19 17 (Address) 1610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11259

CERTIFICATE OF DEATH.

56 D11259

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. Emergency Hosp) (Hospital Mercy) (Hospital) 4 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Gardner

(Residence in Baltimore: No. 427 Market Space St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	?

6-DATE OF BIRTH, ? ....., ..., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
46 abt yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md. Baltimore

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Police Dept.

(Address).....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed)..... (Coroner) M. D.

Dec 18, 1917 (Address) 163 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Gentleman In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

DEC 26 1917

Commissioner of Health.

20398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11260

CERTIFICATE OF DEATH.

175 D11260

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Mann (W. Mann)

(Residence in Baltimore: No. 19 N. Frederick St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Man	White	?

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ...74....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 031

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Police Dept

(Address).....

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9, 1917.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, ~~autopsy or inquiry~~) ~~.....~~find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured legs Caused by being run over by an auto truck accidentally (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Fractured legs duration

(Duration).....yrs.....mos.....ds.

(Signed) W. J. Riley M. D. (Coroner.)

Dec 10, 1917 (Address) 1639 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
DEC 26 1917
ROBERT E. CARTER
Superintendent
Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11261 D11261

CERTIFICATE OF DEATH.

x92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Leadenhall ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Ellis

(Residence in Baltimore: No. 911 Leadenhall St.: — yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ..., (Month) (Day) 1858 (Year)

7-AGE, 59 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... (General) 243

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Harris

(Address) 911 Leadenhall

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December, 23, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 22, 1917, to Dec, 23, 1917, that I saw h[illegible] alive on Dec, 22, 1917, and that death occurred, on the date stated above, at 2.8 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ....yrs....mos. 5 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Dan'l Franklin M. D.

12/24, 1917 (Address) 122 W Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

DEC 26 1917 JOHNS HOPKINS HOSPITAL

Commissioner Health.

I.D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11262

CERTIFICATE OF DEATH.

13 V D11262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Pennsylvania Ave WARD) 17

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Inf of Alexander & Gladys Carroll

(Residence in Baltimore: No. 1305 Pennsylvania Ave St.; ....yrs,, ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Dec 22, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Alexander Carroll

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Gladys Mollz

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gladys Carroll

(Address) 543 N Hoffman St

15-

Filed....., 191....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1917, to Dec 22 1917, that I saw h[er] alive on Dec 22 1917, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) William E Burton M. D.

Dec 23, 1917. (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL. ....., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
DEC 26 1917
Comptroller Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11263

CERTIFICATE OF DEATH.

150 D11263

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Morris

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	S

6-DATE OF BIRTH, ... 12 (Month) – 21 (Day), 17 (Year)

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 12/24 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. Morris

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Rau Sipes

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 12 (Month) – 21 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 12-21 191 1, to 12-21 191 1, that I saw h[illegible] alive on 12-21 191 1, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration) ..... yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatorum

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Longaker M. D.

12-21, 191 1 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

DEC 26 1917 ROBERT E. HEATHER Burial Permit Clerk Commissioner Health.

10400

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D11264

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3657 Park Heights Ave. St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lingg North

(Residence in Baltimore: No. 3657 Park Heights Ave St.; ..... yrs., 2 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 7, 1915
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 18 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or estsblishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Howard I. North

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Rebecca R. Lingg

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard I. North

(Address) 3657 Park Heights Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7th 1917, to Dec 28th 1917, that I saw h... alive on Dec 28th 1917, and that death occurred, on the date stated above, at 7.26 P m.

The CAUSE OF DEATH* was as follows:

.....

..... Tox Emia .....

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Suppurative Cervical Ad.

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Wm. Geo. Naylor M. D.

Dec 26th, 1917. (Address) Pikesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cemy	Dec. 27, 1917.
20-UNDERTAKER Albert C Fuller	ADDRESS 221 N Bradford

Wm Geo Naylor Pikesville.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11265 HEALTH DEPARTMENT—CITY OF BALTIMORE D11265

CERTIFICATE OF DEATH. 109

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 630 S. Fremont St. 21 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Presti

(Residence in Baltimore: No. 630 S. Fremont St.: yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Dec. (Month) 26 (Day), 1850 (Year)

7-AGE. 66 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): Shop

9-BIRTHPLACE. (State or Country). Italy

PARENTS.
10-NAME OF FATHER. Vincent Presti
11-BIRTHPLACE OF FATHER (State or Country). Italy
12-MAIDEN NAME OF MOTHER. Mary Felicci
13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph. Presti
(Address) 630 S Fremont

15-
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Strangulated Hernia
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) C. E. Driscoll M. D.
Dec 25, 1917. (Coroner) (Address) 1211 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Vincents Cemetery
DATE OF BURIAL. Dec 27, 1917

20-UNDERTAKER James Dignan & Son
ADDRESS 1000 S. Paca St

ROBERT R. KRAUFER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11266 ✓ D11266

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 509 S. Spring St ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Johns

(Residence in Baltimore: No. 509 S. Spring St

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Negro

5-SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE. ..... yrs. 8 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. White Johns

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Belle Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bell Johns

(Address) 509 S Spring st

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 23, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Byrnes Jones M. D.
(Coroner.)

Dec 25, 1917 (Address) 710 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER John W Henderson

ADDRESS 31 N Caroline

DEC 26 1917 ROBERT B. CRAUTEN

Spec.—8-24-14—M. & T.—2000 Blks.

D11267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D11267

1-PLACE OF DEATH 163

CITY OF BALTIMORE: (No. 163 E Randall ST.; 24 WARD) REGISTERED No. C

2-FULL NAME Howard B Lockhart

(Residence in Baltimore: No. 150 E Randall St.; 40 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 7, 1853
(Month) (Day) (Year)

7-AGE, 64 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer), R R 073

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Josiah Lockhart

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Amanda Pugh

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen V Lockhart

(Address) Lakewood Apts.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1917, to Dec 24 1917, that I saw him alive on Nov 5 1917, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) not known

CONTRIBUTORY (Secondary) Same

(Duration) yrs. mos. ds.

(Signed) Howard Stubbs M. D.

12/24, 1917. (Address) 1819 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 28 1917.

20-UNDERTAKER Chamberlain & Co

ADDRESS 715 Light

DEC 26 1917 ROBERT R. KRAUTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11263

CERTIFICATE OF DEATH.

REGISTERED NO. C. 102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lasserman

(Residence in Baltimore: No. 108 N. Pine St

St.: 12 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown 1 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 650

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Lasserman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. J. Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 191 7, to Dec 26 191 7, that I saw h[illegible] alive on Dec. 26 191 7, and that death occurred, on the date stated above, at 4.42 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer

(Duration) yrs. mos. ds.

(Signed) Wm. R. Reed M. D.

Dec 26, 191 7. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 108 N Pine St

19-PLACE OF BURIAL OR REMOVAL, Peter Rozedale — DATE OF BURIAL, Dec 27 191 7

20-UNDERTAKER Mgr Lanser — ADDRESS 1107 E Balto

DEC 29 1917 ROBERT E. CRAUTER Registrar of Vital Statistics

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11269

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

49 D11269

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Bradford ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Pulbert

(Residence in Baltimore: No. 411 N. Bradford St.; ....yrs....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Not Known ....., 1..... (Month) (Day) (Year)

7-AGE, 72 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Frank Kmela

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Pulbert

(Address) 411 N Bradford St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1917, to Dec 26 1917, that I saw h-er alive on Dec 26 1917, and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ...yrs. ...mos. 1 ds.

(Signed) H. Klemola M. D.

Dec 26, 1917. (Address) 60 E Mulberry St

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 28, 1917.

20-UNDERTAKER Frank Brach & Son — ADDRESS 1906 Eastlund Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D11270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11270

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred J. Wittler

(Residence in Baltimore: No. 133 d N. Caroline St.: 37 yrs., 11 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, January (Month) 23 (Day), 1880 (Year)

7-AGE, 37 yrs. 11 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Solicitor for 071
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore American

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Wittler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Wilhelmina Heise

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Wittler

(Address) 1334 N. Caroline St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7 1917, to Dec 26 1917, that I saw h m alive on Dec 26 1917, and that death occurred, on the date stated above, at 12 50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 27 ds.

CONTRIBUTORY (Secondary) Gun Wound of Lungs

(Duration) ....yrs. ....mos. 5 ds.

(Signed) P. Stackerton M. D.

Dec 26, 1917. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 17 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 133 d N. Caroline

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetary

DATE OF BURIAL, Dec 28, 1917.

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11271

CERTIFICATE OF DEATH.

120 D11271

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 957 N. Chester ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Smith

(Residence in Baltimore: No. 957 N. Chester st St.; yrs., 42 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Packer
(b) General nature of industry, business, or establishment in which employed (or employer): in Factory

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert E. Collins

(Address) 957 N. Chester st

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24 (Month) (Day) 17, 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Miller M. D. (Coroner.)

Dec 26 191. (Address) 1 E. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetary

DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER Christian Miller

ADDRESS 2334 Jefferson st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D11272

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Castle ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Müller

(Residence in Baltimore: No. 225 N. Castle St.; 60 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November 3, 1839 (Month) (Day) (Year)

7-AGE, 78 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, George Müller Sr

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Louisa Leppert

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Müller

(Address) 225 N. Castle st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 25, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17th 191 7, to Dec 25th 191 7, that I saw h[illegible] alive on Dec 24th 191 7, and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Asthma

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetary — DATE OF BURIAL, Dec 28., 1917.

20-UNDERTAKER Christian Miller 233 — ADDRESS Jefferson st

D11273

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 ✓ D11273

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 920 W Franklin St ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Nicholas Gwinn

(Residence in Baltimore: No. 920 W. Franklin St. St.: yrs. 60 mos. ds.)

WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: Oct 8, 1860 (Month) (Day) (Year)

7-AGE: 57 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk- Oil Works
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Nicholas L. Gwinn

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Emily E. Stein

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A. J. Gwinn

(Address) 920 W Franklin St

15-

Filed ....., 191.....

REGISTRAR

DEC 26 1917 ROBERT P. [illegible]

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 25, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1915 to Dec 25 1917 that I saw h[illegible] alive on Dec 25 1917 and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) 1 yrs. 6 mos. ds.

(Signed) Standish McCleary M. D.

Dec 26 1917 (Address) 1609 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet

DATE OF BURIAL: Dec 28, 1917

20-UNDERTAKER: Geo W Little

ADDRESS: 531 N Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D11271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11271

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N. Fremont Av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Miller

(Residence in Baltimore: No. 521 N. Fremont av. St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 7, 1842
(Month) (Day) (Year)

7-AGE, 75 yrs. 3 mos. 17 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Meitzel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Miller

(Address) 521 N Fremont Av

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 19th 1917, to Dec. 24th 1917, that I saw h[er] alive on Dec. 24th 1917, and that death occurred, on the date stated above, at 8.45 m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt. J. Murray M. D.

Dec. 24 191.7 (Address) 510 N. Fremont Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western | DATE OF BURIAL, Dec. 27, 1917.

20-UNDERTAKER Geo W Little | ADDRESS 531 N Fremont Av

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D11275

REGISTERED No. C.....

1-PLACE OF DEATH 2a street and 3800 Black

CITY OF BALTIMORE (No.) 3 Frederick Ave ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Blaney

(Residence in Baltimore: No. 756 Sarah Anne St.: yrs., 46 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, unknown (Month) ....., 1 (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper on furniture wgn
(b) General nature of industry, business, or establishment in which employed (or employer): Hecht Co 623

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Blaney

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Keel

(Address) 1309 W Mulberry St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed & Chest Ruptured-etrating injury heart thereof Accidently by Street Car striking his wagon throwing him under car instantly

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Kenlon M. D. (Coroner.)

Dec 26 191... (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem DATE OF BURIAL, 1917

20-UNDERTAKER George J Smith ADDRESS 1600 Gilmor St

(Over)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D11276

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1445 Towson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Graves

(Residence in Baltimore: No. 1445 Towson St.; ....yrs,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 28 (Day), 1873 (Year)

7-AGE.	If LESS than 1 day,
44 yrs. ....mos. 28 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, Charles F. graves

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Kate Tifel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Graves

(Address) 1445 Towson

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 26th, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1917, to Dec 26th 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Grippe (Pneumonia)

(Duration) 1 yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) 0 yrs. — mos. 15 ds.

(Signed) [illegible] M. D.

Dec 26, 1917 (Address) 1778 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cem.	Dec 28, 1917
20-UNDERTAKER M. L. Flynn	ADDRESS 1742 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11277

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 ✓ D11277

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N Duncan ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mathew. Coshan. Kocan

(Residence in Baltimore: No. 205 N Duncan St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. ..... July (Month) ..... 29 (Day) ....., 1842 (Year)

7-AGE. ..... 75 yrs. ... 5 mos. ... 22 ds.

If LESS than 1 day, ... hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Dont know

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country). Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Michael Coshan

(Address) ..... 205 N Duncan

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... December (Month) ..... 24 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1917, to Dec 24 1917, that I saw h[illegible] alive on Dec 23 1917, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

..... (a) .....
..... Lobar Pneumonia .....
.....
..... (Duration) ..... yrs. ..... mos. ..... 4 ..... ds.

CONTRIBUTORY (Secondary) ..... Exhaustion .....
..... (Duration) ..... yrs. ..... mos. ..... 1 ..... ds.

(Signed) ..... Adolph C. Eisenhart ..... M. D.

Dec 26, 1917. (Address) ..... 201 Orleans St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	December 27 1917.
20-UNDERTAKER	ADDRESS
Rendell Wiffleson	378 Mon

NB—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11278

151 ✓

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Madeira St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie Petz

(Residence in Baltimore: No. 920 N. Madeira St.; ....yrs., ...mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Infant

6-DATE OF BIRTH, Dec 24, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Baltr

PARENTS.

10-NAME OF FATHER, Petz, Thomas

11-BIRTHPLACE OF FATHER (State or Country), Baltr

12-MAIDEN NAME OF MOTHER Elizabeth Hirt

13-BIRTHPLACE OF MOTHER (State or Country), Baltr

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Petz

(Address) 920 N Madeira St

15-

Filed....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Dec 27, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Dec 27, 1917.

20-UNDERTAKER [illegible] | ADDRESS 1406 Eutaw Pl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 D11279

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Israel

(Residence in Baltimore: No. 642 N. Fayette St. St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 24 (Day) 1852 (Year)

7-AGE, 65 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... " .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John R. Israel

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza Turman

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp.

15- 7

Filed ..... 191.....

Registrar.

DEC 27 1917 ROBERT E. KARSTEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 191 7 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 191 7, to Dec 26 191 7, that I saw him alive on Dec 26 191 7 and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate Gland

about (Duration) ....yrs. 6 mos. ....da.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ....yrs. ....mos. ....da.

(Signed) Edward H. Resnick M. D.

Dec 26, 191 7 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 17 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 642 N. Fayette St.

Former or usual residence 642 N. Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, Dec 26, 191 7.

20-UNDERTAKER John J. Cowan and Son ADDRESS 901 Hollins St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3603

D11280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11280

175 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Monroe Yates

(Residence in Baltimore: No. 323 N. Charles St.)

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fisher
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER, unk

11-BIRTHPLACE OF FATHER (State or Country), unk

12-MAIDEN NAME OF MOTHER unk

13-BIRTHPLACE OF MOTHER (State or Country), unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15-

Filed....., 191.....

Registrar.

DEC 27 1917

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Fract. Skull and Hem. cerebral caused by hanging bimself by tieing (Bima. R.R.) (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley (Coroner.) ..... M. D.

Dec 26, 191.. (Address) 1639 Bandy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel cemetery	Dec. 27, 191..
20-UNDERTAKER Felix B Pye	ADDRESS 1025 Mulberry

D.

Spec.—8-24-14—M. & T.—2000 Blks.

D11281

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D11281

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 East Preston St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred E. Washburn

(Residence in Baltimore: No. 2213 East Preston St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 20 (Day), 1901 (Year)

7-AGE, 16 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George W Washburn

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Neale Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C Neale Washburn

(Address) 2213 E—Preston

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1917, to Dec 25 1917, that I saw her alive on Dec 24 1917, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) ....yrs. 6 mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs.....mos.....ds.

(Signed) B O Herzog MD M. D.

Dec 25, 191.7. (Address) 1305 N Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, 12 27, 191.7

20-UNDERTAKER Williams Cook

ADDRESS 508 N North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT L. KRAUTER

DEC 31 1917

BUREAU OF VITAL STATISTICS

B.O. Herzog MD 1305 N. Patterson Park Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D11282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11282

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Eastern Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gardner

(Residence in Baltimore: No. 2218 Eastern Ave St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Sept (Month) 15th (Day), 1832 (Year)

7-AGE, 85 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Haas

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Lnandt

(Address) 2218 Eastern Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23, 1917, to Dec 24 1917, that I saw her alive on Dec 23, 1917, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

..... Arterio-Sclerosis .....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxiation Carbon

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M. D.

12/25/1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. | DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER, J. Bauder & Sons | ADDRESS Pulaski St

DEC 27 1917 BUREAU OF STATISTICS Burial Permit

15

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11283

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2416 E Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah E. Clabaugh.

(Residence in Baltimore: No. 2416 E Madison St. St.; 79 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb (Month) 1 (Day), 1838 (Year)

7-AGE, 79 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-work at home.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Jacob Wilson

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles B. Clabaugh

(Address) 2416 E. Madison St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 24 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1917, to Dec 24 1917, that I saw h er alive on Dec 24 1917, and that death occurred, on the date stated above, at 10.45a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) 1 yrs. 7 mos. ds.

(Signed) Louis Voss M. D.

Dec 26 1917 (Address) 1501 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11284

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Castle ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma G. Smith

(Residence in Baltimore: No. 514 N. Castle St.; 20 yrs., 2 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 3rd (Day), 1897 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. 2 mos. 23 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas E. Tracy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E. Doyle

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E. Tracy

(Address) 514 N. Castle St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1917, to Dec 26 1917, that I saw her alive on Dec 26 191.., and that death occurred, on the date stated above, at 2359 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

Hypertension — Chronic

Pitted Kidney

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Oedema of Lung

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 26, 1917. (Address) 604 N. [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 28, 1917
20-UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X132 D11285

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia M. Legg

(Residence in Baltimore) No. Stevensville Md (out St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1892 (Year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Wm E. Gardner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Record

(Address) University Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 26, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/26 — 1917, to 12/26 1917, that I saw h[er] alive on 12/26 1917, and that death occurred, on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Gen. Peritonitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pelvic Abscess 7 D

Salpingitis (Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. Cullen M. D.

12/27, 191.7 (Address) Queen Anne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 1 yr. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Stevensville Md.

19-PLACE OF BURIAL, OR REMOVAL. Chester Town Md. DATE OF BURIAL. 12/27, 1917

20-UNDERTAKER Chas. F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11286

CERTIFICATE OF DEATH.

86

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. Alem M. Litzinger

(Residence in Baltimore: No. 127 E. North Av St.; 22 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 16. (Day) 1872 (Year)

7-AGE, 45 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer) 0524

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, William D. Litzinger

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amelia C. Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Childs Litzinger

(Address) 127 E. North ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1917, to Dec 26 1917, that I saw him alive on Dec 26 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Renal Tuberculosis

Following Injection of Novo

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Renal Tuberculosis now

(Duration) yrs. mos. ds.

(Signed) Edward H. Dennett M. D.

Dec 26 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 127 E. North Ave

Former or usual residence 127 E. North Ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec. 28, 1917.

20-UNDERTAKER John O'Mitchell

ADDRESS 1208 W. Fayette

D11287

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 D11287

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1717 Linden ave ST.: 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horatio H. Webster

(Residence in Baltimore: No. 1717 Linden ave St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	married

6-DATE OF BIRTH ..... (Month) ..... (Day) , 1841 (Year)

7-AGE 76 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE (State or country) New Hampshire

PARENTS

10-NAME OF FATHER Leet Webster

11-BIRTHPLACE OF FATHER (State or country) New Hampshire

12-MAIDEN NAME OF MOTHER Susan

13-BIRTHPLACE OF MOTHER (State or country) New Hampshire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred M. Webster

(Address) 1717 Linden ave

15-

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 26th (Month) (Day) , 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1917, to Dec 26th, 1917, that I saw h[illegible] alive on Dec 26th, 1917, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 10 ds

Contributory (SECONDARY) Myocarditis —

(Duration) [illegible] yrs. mos. ds.

(Signed) Chas Lockwood M. D.

Dec 27, 1917. (Address) 132 Park ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL Faudwich N. H. | DATE OF BURIAL Dec 28, 1917

20-UNDERTAKER John O. Mitchell | ADDRESS 1200 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D11288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11288

CERTIFICATE OF DEATH.

40 X

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Fowle

(Residence in Baltimore: No. 1 mos. 2 days St.; ...yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, November 27, 1853 (Month) (Day) (Year)

7-AGE, 64 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
X (b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Turkey

PARENTS.

10-NAME OF FATHER, Wm A. Farnesworth

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Ely

13-BIRTHPLACE OF MOTHER (State or Country), N. H.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1917, to Dec 26 1917, that I saw her alive on Dec 26 1917, and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Sarcoma of bone

mon

Operation (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of liver

(Duration) yrs. 1 mos. ds.

(Signed) C H Bloomfield M. D.

Dec 26, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Auburndale Mass

19-PLACE OF BURIAL OR REMOVAL, Woburn, Mass. DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER John D. Mitchell ADDRESS 120 W. Fayette St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D11289

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 621 Ethelwood Lane ST.; 9 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Christian C. Gensel

(Residence in Baltimore: No. 621 Ethelwood St.: 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: June (Month) 23, (Day) 1840 (Year)

7 AGE: 77 yrs. 6 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Stone Grinder (b) General nature of industry, business, or establishment in which employed (or employer): 080

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Gensel

(Address) 415 Forest Rd. Balto

15.

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 25 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1917, to, Dec 18 1917, that I saw h~~im~~ alive on Dec 18, 1917, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung.

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. mos. ds.

(Signed) R. J. Stuckhart Jr M. D.

Dec 25, 1917 (Address) 632 Oakland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec 27, 1917

20 UNDERTAKER: H. C. Wadefield

ADDRESS: 917 Fairmount Ave

1111

D11290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11290

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1105 Druid Hill St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jolly

(Residence in Baltimore: No. 1105 Druid Hill Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Single

6-DATE OF BIRTH, May 7, 1915
(Month) (Day) (Year)

7-AGE, 2 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore,

PARENTS.

10-NAME OF FATHER, Edward Johnson

11-BIRTHPLACE OF FATHER (State or Country) Balt Dark Jolly

12-MAIDEN NAME OF MOTHER Baltimore

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 1105 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cold & Exposure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Dec 26, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 27 191..
20-UNDERTAKER John A. Bishop	ADDRESS 1105 Druid Hill Ave

DEC 27 1917 EUGENE E. KNAUER

Spec.—8-24-14—M. & T.—2000 Blks.

D11291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D11291

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 E. Pratt st ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chia Rachel Rosenstrach

(Residence in Baltimore: No. 1012 E. Pratt st St.; 15 yrs.,.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1837
(Month) (Day) (Year)

7-AGE, 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jack Levis

(Address)..... 1411 E. Balt st

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 27 1917, that I saw her alive on Dec 26 1917, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Complicated Chronic
Myocarditis
..... Uremia
..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary):
Cardiac failure (Duration) yrs. mos. 2 ds.

(Signed) L. H. Ephraim M. D.

Dec. 27, 1917. (Address) 218 S. Exeter st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Rosedale | DATE OF BURIAL, 12-28-17, 191...

20-UNDERTAKER Jack Levis | ADDRESS 1411 E. Balt st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11292

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1435 Nilliam ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME alice a Hunt

(Residence in Baltimore: No. 1435 Nilliam St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	white	Marid

6-DATE OF BIRTH, ...May.... (Month) 7 (Day) 1856 (Year)

7-AGE 59 ....yrs. ....mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Keerbey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rebecca J Cofrill

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr E. Hunt

(Address) 1435 Nilliam St

15-

Filed ....., 191....

....Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1917, to Dec 27 1917, that I saw h.r alive on Dec 26 1917, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

1 Chronic Nephritis

Dropsy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Bronchitis of

Pneumonia

(Duration) 2 yrs. ....mos. ....ds.

(Signed) R. E. Campbell M. D.

Dec 27, 191. (Address) 1646 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Michael md	Dec 30 1917
20-UNDERTAKER	ADDRESS
W J Dickerson	1116 S Penn

DEC 27 1917

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D11293 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D11293

CERTIFICATE OF DEATH. 92

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Etting St ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Brooks

(Residence in Baltimore: No. 1721 Druid Hill ave St.: ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Blk	Married

6-DATE OF BIRTH, ...(Month)...., ...(Day)...., 1872 (Year)

7-AGE, 45 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore
(b) General nature of Industry, business, or establishment in which employed (or employer): —

504 074

9-BIRTHPLACE, (State or Country), Calvert County Md

PARENTS.

10-NAME OF FATHER, Peter Brooks

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mollie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Stewart

(Address) 1721 Druid Hill ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22nd 1917, to Dec 25th 1917, that I saw him alive on Dec 25th 1917, and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Pleurisy

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Heart Asthenia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) A. B. Blacock M. D.

Dec 26, 1917. (Address) 1844 Bruna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cove Point Md — DATE OF BURIAL: Dec 28, 1917

20-UNDERTAKER: H. Arnold Handley — ADDRESS: 578 N Bond

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D11291

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2349 W. Baltimore St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Williamson

(Residence in Baltimore: No. 1442 N. Broadway St.; 41 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. Unknown ....., 1876
(Month) (Day) (Year)

7-AGE. 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). .....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Wagner

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mrs. Simmons

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cathrine Turner

(Address) 1442 N. Broadway

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 21, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11 1917, to Dec. 21 1917, that I saw h[illegible] alive on Dec. 21 1917, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) 1 yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Asthenia

..... (Duration) ..... yrs. 2 mos. 11 ds.

(Signed) William F. Howe M. D.

Dec. 21 191 7 (Address) 1402 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St. Vincents Catholic

DATE OF BURIAL. Dec. 24, 1917

20-UNDERTAKER Roberts & Turner

ADDRESS 1742 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11295 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D11295

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N. Lakewood Ave ST., 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benedict Wallblick

(Residence in Baltimore: No. 814 N. Lakewood Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH Sept 20, 1890
(Month) (Day) (Year)

7-AGE, 27 yrs. 3 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scale Splicer
(b) General nature of industry, business, or establishment in which employed (or employer): C. & P. Telephone Co.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Chas. Wallblick

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Hannaman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. Wallblick

(Address) 814 N. Lakewood Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1917, to Dec 25 1917, that I saw him alive on Dec 24 1917, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

a Bronchio-Pneumonia

b

c

(Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Edward J. Coot M. D.

1/2/26, 191.7. (Address) 413 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	Dec 28, 1917
20-UNDERTAKER	**ADDRESS**
Geo M. Fink	811 N Howard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 27 1917

3976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 11296 Found

CERTIFICATE OF DEATH.

184 D 11296

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Kenwood Ave Sewer ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL particulars.

3-SEX. unknown

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, unknown (Month), 1 (Day) (Year)

7-AGE, unknown yrs. unknown mos. ds.

If LESS than 1 day, 12 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... 000
(b) General nature of industry, business, or establishment in which employed (or employer) unknown 000

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Coroner Baker Dalton

(Address) Bank + Broadway

15-

Filed ....., 191....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquisition (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning. Went through Sewer at foot of Kenwood Ave

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thomas Dunn Gilman M. D. (Coroner)

Dec 11, 1917 (Address) 16 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

DEC 26 1917

Katie Hauf.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11297 ✓ D11297

CERTIFICATE OF DEATH.

1 20

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2255 W Baltimore St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Hauf

(Residence in Baltimore: No. 2255 W Baltimore St.; 44yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Married

6-DATE OF BIRTH, June (Month) 19 (Day), 1873 (Year)

7-AGE, 44 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home 037

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Doulon

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Blondell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Hauf

(Address) 2255 W Balto St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 25 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) yrs. mos. ds.

(Signed) James M Doulon M. D. (Coroner.)

Dec 27, 1917. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Dec 29 1917
20-UNDERTAKER	ADDRESS
F. A Kraus	103 S Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D11298

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 ✓

D11298

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Hanover st ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred I Duckett

(Residence in Baltimore: No. 1928 Hanover St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6-DATE OF BIRTH July (Month) 29 (Day) 1917 (Year)

7-AGE — yrs. 4 mos. 29 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto

PARENTS

10-NAME OF FATHER Charles Duckett

11-BIRTHPLACE OF FATHER (State or country) Balto

12-MAIDEN NAME OF MOTHER Dora Slagle

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dora Duckett

(Address) 1928 Hanover st

15-

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec. (Month) 27 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22, 1917, to, Dec 27 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

1. Lobar Pneumonia

(Duration) yrs mos 4 ds

Contributory (SECONDARY) No History

(Duration) yrs mos ds

(Signed) Manley Stone M. D.

Dec 27, 1917 [Address] 729 Eutaw

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill County DATE OF BURIAL Dec 29. 1917

20-UNDERTAKER F. A. Sclause ADDRESS 703 Hanover St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 11299

CERTIFICATE OF DEATH.

81 D 11299

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Scott. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Greason

(Residence in Baltimore: No. 612 Scott St.; Lyte Time yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, September 12, 1846. (Month) (Day) (Year)

7-AGE, 71 yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)..... 047

373

9-BIRTHPLACE. (State or Country) Md. Maryland

PARENTS.

10-NAME OF FATHER, Thomas Greason

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Dundon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Greason

(Address) 612 Scott St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 24 1917, and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia & Chronic Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Duration) yrs. mos. ds.

(Signed) Montez Tood M. D.

Nov. 26th 191[illegible]. (Address) 729 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo P Kerby ADDRESS Gaith & Hayward

DEC 27 1917 ROBERT B. FRAZIER REGISTRAR

DEC 28 1917

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11300

CERTIFICATE OF DEATH.

91 D11300

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1543 Ridgely ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma E. Creamer

(Residence in Baltimore: No. 1543 Ridgely St.; Life Time (Yrs., mos., ds.))

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, or DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, October (Month) 21st (Day) 1917 (Year)

7-AGE, ...yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George L Creamer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Helen Sheppard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. L. Creamer

(Address) 1543 Ridgely St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December (Month) 26 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1917, to Dec 26 1917, that I saw her alive on Dec 25 1917, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Primary

(Duration)....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Morley Ford M. D.

Dec 26, 1917. (Address) 724 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo. A. Gerber

ADDRESS Balto Md

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

P11301

CERTIFICATE OF DEATH.

172 ✓ B11301

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Cloverdale Rd ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Slavin

(Residence in Baltimore: No. 1215 Cloverdale Rd St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, 10 – 20 (Month) (Day), 1837 (Year)

7-AGE, 80 yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas McDermott

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Murray

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Loughlon

(Address) 1215 Cloverdale Rd

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 191 7, to Dec 24 191 7, that I saw h e alive on Dec 24 191 7, and that death occurred, on the date stated above, at 11-30 m.

The CAUSE OF DEATH* was as follows:

1 Bronchio-Pneumonia 000

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture L R Hip

(Duration) yrs. mos. 7 ds.

(Signed) Edward O'Murray M. D.

Dec 27, 191... (Address) 55 E Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Dec 28, 1917

20-UNDERTAKER, John J Fahey & Son — ADDRESS, 1918 Eutaw

(Area)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D11302

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Curley ST.; 6 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Susia

(Residence in Baltimore: No. 414 N. Curley St.; 3 yrs., 5 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July 13th (Month) (Day), 1914 (Year)

7-AGE, 3 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Frank Susie

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Eva Hassett.

13-BIRTHPLACE OF MOTHER (State or Country), Centreville Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Susie.

(Address) 414 N. Curley St.

15-

DEC 27 1917 ROBERT R. KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26th (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24 1917, to Dec 26 1917

that I saw h[illegible] alive on 11 a 1917

and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Croup

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. C. O'Hesler M. D.

Dec 27 1917. (Address) 1601 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Dec 27, 1917

20-UNDERTAKER Lilly & Zeller — ADDRESS 403 S Wolfe St

3.30 P. M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11303

CERTIFICATE OF DEATH.

10 D11303

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Mae Mullen

(Residence in Baltimore: No. Childs Hosp Franklin & Schroeder St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. May 16, 1917
(Month) (Day) (Year)

7-AGE. .....yrs. 7 mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Edna McMullen

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 21, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1917, to Dec 21 1917, that I saw her alive on Dec 21 1917, and that death occurred, on the date stated above, at 9 40 p m.

The CAUSE OF DEATH* was as follows:

.....Meningitis (influenza).....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Harry P. Leonard M. D.

Dec 23, 191.. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Franklin & Schroeder Sts

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 24 1917 ROBERT P. KRAUTER Commissioner of Health.

DEC 20 1917 ROBERT P. KRAUTER Commissioner of Health.

JOHNS HOPKINS HOSPITAL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20104

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11301

CERTIFICATE OF DEATH.

1521 D11301

1-PLACE OF DEATH 807 Somerset St. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby McNeal

(Residence in Baltimore: No. ..... St.: ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	

6-DATE OF BIRTH, Dec 27, 1917.
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 1 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James McNeal

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Mary McNeal

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 26 1917, that I saw h.. alive on Dec 26 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

Dec 28, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 27 1917 ROBERT P. KRAUTZ

JOHNS HOPKINS HOSPITAL DEC 27 1917

Supervising Inspector Health.

L6405

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11305 ✓ D11305

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N Fulton Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice J. Smyth

(Residence in Baltimore: No. 725 N Fulton ave St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. January 28, 1838
(Month) (Day) (Year)

7-AGE, 79 yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired 000
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country), England

PARENTS.

10-NAME OF FATHER, William Smyth

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Ellen Mawer.

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stewart L. Smyth

(Address) 725 N. Fulton ave.

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 27th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29th 1917, to December 27th 1917.

that I saw h.. alive on Dec 27th 1917,

and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Senile Dilatation of heart -

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Hemiatrophy -

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Page E. dumont M. D.

Dec 27 1917 (Address) 311 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	Dec 29, 1917.
20-UNDERTAKER Albert E. Fuller	ADDRESS 22 n Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 27 1917 ROBERT R. KRAUTER

Dr. Edwards Guilford

Spec.—8-24-14—M. & T.—3000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11306 154 D11306

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Eutaw Place, ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Sonneborn, Sr.,

(Residence in Baltimore: No. 1608 Eutaw Place, St.; 72 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married,

6-DATE OF BIRTH, Feby. (Month) 18th; (Day) 1826 (Year)

7-AGE, 91 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wholesale 045
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing Mnfg.,

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, Moses Sonneborn,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. H. Sonneborn Jr.

(Address) 1608 Eutaw Place,

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 26th. (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1887 191..., to ...191...,

that I saw h[illegible] alive on [illegible] 26 Dec., 191 7,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

[illegible] fractured [illegible]
from the [illegible] of old
age. half hour

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration)...yrs...mos...ds.

(Signed) Dr. Act. Arrington M. D.

Dec 28th 191 7 (Address) 1727 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oheb Shalom, DATE OF BURIAL. Dec. 28th, 191 7

20-UNDERTAKER Hart & Sondheim ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 27 1917 ROBERT E. KRAUTER

Mad 6277

D11307 John Neville

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 Monument St.; WARD)

2-FULL NAME John Neville.

(Residence in Baltimore: No. 1513 Monument St.; yrs.. mos. ds.)

REGISTERED No. C 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mary

6-DATE OF BIRTH, May 24, 191?

(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Neville

11-BIRTHPLACE OF FATHER (State or Country). N Carolina

12-MAIDEN NAME OF MOTHER Venie Read

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brother Venie Neville

(Address) 15 E Madison St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 191?

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis (Pneumonia)

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

(Dec 26) 191?. (Address) 1 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury Tenn

DATE OF BURIAL, Dec 28, 191?

20-UNDERTAKER Mrs R A Elliott

ADDRESS 506 East St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D11308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D11308

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 East St. St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Holland

(Residence in Baltimore: No. 109 East St.

St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Single

6-DATE OF BIRTH,

....., 1..... (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. and ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo Holland

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Rachel Morris

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Cummings

(Address) 109 East

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Tetanus Traumatica.....

.....Tetanus Traumatica.....

(Duration).....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) .....
(Coroner.) .....M. D.

Dec 27, 1917 (Address) 109 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, Dec. 28, 1917.

20-UNDERTAKER John W Henderson — ADDRESS 31 N. Caroline

N 45346

DEC 28 1917 ROBERT E. KRAUTZ DEPUTY REGISTER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—5-19-13—M. & T.—500 Bks.

D11309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 E Clement St. WARD) 24

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Wm Laught.

(Residence in Baltimore: No. 618 E Clement St.; 9 mos. yrs... mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 22, 1916. (Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 4 ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm Laught.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary Kirby

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Laught

(Address) 618 E Clement.

15-

Filed....., 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/5/16 1917, to 12/26 1917, that I saw him alive on 12/26 1917, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) J. Dunlington M. D.

12/26 1917. (Address) 10 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL. 12/28 1917

20-UNDERTAKER J. Fen McCully ADDRESS 120 E. Fort

D.

Spec.—8-24-14—M. & T.—2000 Bks.

D11310

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D11310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. York St. ST.; 27 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alverta J Brown

(Residence in Baltimore: No. 16 W York St.: ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ....., 1886 (Year)

7-AGE, 31 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Geo Brown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Gray

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Scott

(Address) 522 N Eee St

15-

Filed....., 191.....

Registrar.

B

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 22 1917, to Dec. 27th 1917, that I saw h[er] alive on Dec. 27th 1917, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

.....1.....

Cerebral Hemmorhage

.....

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (Duration) about 1 yr. yrs. ....mos. ....ds.

(Signed) ..... M. D.

Dec 28, 1917. (Address) 136 W Hoffman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Dec 30, 1917

20-UNDERTAKER Jno A Goodwin ADDRESS 142 Custer St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11311 D11311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C 479

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Rae

(Residence in Baltimore: No. 349 Courtland St. St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, July (Month) 15 (Day) 1858 (Year)

7-AGE, 59 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Coal & Feed Yard

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob H. Rae

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Alice Cunningham

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1917, to Dec 26 1917, that I saw him alive on Dec 26 1917 and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemic Hyperpyrexia

Duration Not Known

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward [illegible] M. D.

Dec 26, 1917. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. ½ ds. In the State 54 yrs. mos. ds.

Where was disease contracted, if not at place of death? 349 Courtland St

Former or usual residence 349 Courtland St

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 28 1917

20-UNDERTAKER Wallace Cook

ADDRESS 504 E Watts Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D11312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11312

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2019 Edmondson Ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie E Lewis

(Residence in Baltimore: No. 2019 Edmondson Ave St.; 9 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, March 12, 1868
(Month) (Day) (Year)

7-AGE, 49 yrs. 9 mos. 15 ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House
(b) General nature of industry, business, or establishment in which employed (or employer) Work

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J Lewis

(Address) 2019 Edmondson ave

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 1st 1917, to Dec 27th 1917, that I saw h[illegible] alive on Dec 26th 1917, and that death occurred, on the date stated above, at 6 45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

~~Hemiplegia~~

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia (Left Side)

(Duration) yrs. 1 mos. ds.

(Signed) Chas. A. Whitemore M. D.

Dec 27th 1917. (Address) 530 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cem't

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER William Cook

ADDRESS Pac & North

Spec.—8-24-14—M. & T.—5000 Blks.

D11313

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D11313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2743 N. Fulton St.; 15th WARD) REGISTERED NO. C 120

2-FULL NAME Herman H Sappington

(Residence in Baltimore: No. 2743 N. Fulton St.; (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1yr 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Married

6-DATE OF BIRTH, March 2, 1885
(Month) (Day) (Year)

7-AGE. 32 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER John Faulstich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Carrie Zigler

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Sappington

(Address) 2743 N. Fulton

15-

Filed....., 191.....

....., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1917, to Dec 26 1917, that I saw her alive on Dec 26 1917, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion of Heart

(Duration) yrs. mos. 2 ds.

(Signed) Fred L Jewett M. D.

Dec 27, 1917. (Address) 2516 Penn Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER Mullaine & Co — ADDRESS 507 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 28 1917 ROBERT R. CRAUFURD

D11314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11314

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1429 Gorsuch St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Clark

(Residence in Baltimore: No. 1429 Gorsuch St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, August 13, 1857.
(Month) (Day) (Year)

7-AGE, 59 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or....mlu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boilermaker
(b) General nature of industry, business, or establishment in which employed (or employer):

213 086

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John W Clark

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Louisa Hatton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Clark

(Address) 727 Gorsuch Ave

15-

Filed....., 191....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroners Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Lynch Duckett (Coroner.) M. D.

Dec 27, 1917 (Address) 16 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Dec 29 1917

20-UNDERTAKER	ADDRESS
H Sander & Sons	1710 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D11315

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D11315

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 21 W. Barney ST. 23 WARD)

2-FULL NAME Catherine C Martin

(Residence in Baltimore: No. 21 W. Barney St. 36 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Fem

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Sept (Month) 14 (Day), 1865 (Year)

7-AGE: 52 yrs. 3 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Germany.

PARENTS

10-NAME OF FATHER: Philip Kern

11-BIRTHPLACE OF FATHER (State or country): Germany.

12-MAIDEN NAME OF MOTHER: Sibylla Kern

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Martin

(Address) 21 W. Barney St

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 26 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1917, to Dec 26, 1917, that I saw h alive on Dec 25, 1917, and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) C W Mitchell MD M. D.

Dec 26, 1917 (Address) 1274 Williams St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Western Cem.	Dec 30, 1917
20-UNDERTAKER	ADDRESS
E. Schlosnagle & Son	Eutaw St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11316

CERTIFICATE OF DEATH

X 146 D11316

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No 1017 E Baltimore St. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Fox

(Residence in Baltimore: No. 1017 E Balto St. St.; yrs. mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: May (Month) , 1856 (Year)

7-AGE: 61 yrs. 7 mos. ds. If LESS than 1 day, ... hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 006

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Samuel D Fox

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Mary Young

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grover C Fox

(Address) 1948 N Mulberry

15

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 28 (Month) (Day) , 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 , 1917 . to. Dec 28 — 1917 .
that I saw him alive on Dec 27 — , 1917 .
and that death occurred, on the date stated above, at 3.45 m.
The CAUSE OF DEATH* was as follows:

Sepsis - following
Dental Abscess

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

DEC 28 1917 .191 (Address) ..... OR TWO PHYSICIANS.

*State the DISEASE CAUSING DEATH, or, if DEATH from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Harney Md

19-PLACE OF BURIAL OR REMOVAL: Harney Md. DATE OF BURIAL: Dec 30 , 1917

20-UNDERTAKER: W M Routson ADDRESS: 230 N Greene

Spec.—8-24-14—M. & T.—2000 Blks.

D11317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11317

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 Light St ST.; 22 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wolf Kahn

(Residence in Baltimore: No. 732 Light Street St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
74 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0?

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jno. Lewis

(Address) 1411 E. Baltimore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month), 27 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June, 10 1916, to Dec, 27 1917, that I saw him alive on Dec, 26, 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes (Mellitus)
Coma
(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus
Myocarditis (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) David Frankin M. D.

12/28, 1917 (Address) 122 W Lee St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Cemetery	12/29, 1917
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11318

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3726 Park Heights Ave) (St.) (WARD) 15

REGISTERED No. C 151 D11318

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Joseph Leary

(Residence in Baltimore: No. 3726 Park Heights Ave St.; yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 9th, 1917 (Month) (Day) (Year)

7-AGE: ___ yrs. ___ mos. 18 ds. If LESS than 1 day, ... hrs. or ___ min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Daniel Leary

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Virginia Decker

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Leary

(Address) 3726 Park Heights Ave

15.

Filed ..... 191 ..... REGISTRAR

DEC 28 1917 ROBERT B. KRAUSS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 27, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1917, to Dec 22nd 1917, that I saw h[illegible] alive on Dec 11—, 1917, and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Cancer of Face to Prevent Taking Food

(Duration) yrs. 2 mos. 4 ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. 2 mos. 4 ds.

(Signed) Wm B [illegible] M. D.

..... 191 .... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Memorial — DATE OF BURIAL: Dec 28 1917

20-UNDERTAKER: [illegible] Southard — ADDRESS: 1624-1626 Pennsylvania Ave

D11319 HEALTH DEPARTMENT—CITY OF BALTIMORE D11319

163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 708 Mura St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Neary.

(Residence in Baltimore: No. 708 Mura St. Sick St.: yrs. mos. ds.)

N. B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widd

6-DATE OF BIRTH, April 19, 10
(Month) (Day) (Year)

7-AGE, 7 yrs. 8 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Thomas Neary

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine McEvoy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Neary

(Address) 708 Mura St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Dec 27, 191[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral	Dec 28, 1917.
20-UNDERTAKER H. C. Wadefield	ADDRESS 19 Greenmount Ave

Spec.—5-19-13—M. & T.—500 Bks.

D11320

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D11320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Archer St. ST.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Watson

(Residence in Baltimore: No. 637 Archer St. St.: yrs.. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	M

6-DATE OF BIRTH, 12/15, 1891. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
25 yrs. 3 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Calvert Co. Md

PARENTS.

10-NAME OF FATHER, William Watson

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Sadie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Watson

(Address) 637 Archer St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 26 1917, and that death occurred, on the date stated above, at 10 30/a m.

The CAUSE OF DEATH* was as follows:

I. (a) Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nil

(Duration) yrs. mos. 12 ds.

(Signed) Raymond Brown M. D.

Dec 27, 191.. (Address) 1227 E Oliver St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn County — DATE OF BURIAL, Dec 28, 1917

20-UNDERTAKER Wm H Kessler — ADDRESS 416 N Howard St

DEC 28 1917 ROBERT E. KRAUSS

Spec.—8-24-14—M. & T.—2000 Bks.

D11321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D11321

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 573 S Robinson St.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Phillips

(Residence in Baltimore: No. 513 S Robinson St.; 67 yrs., ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov (Month) 12 (Day), 1841 (Year)

7-AGE, 76 yrs. 1 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A Myers

(Address) 573 S Robinson St

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1917, to Dec 26 1917, that I saw h[illegible] alive on Dec 25 1917, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

about

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. ... mos. ... ds.

(Signed) Geo. Heller M. D.

Dec 29, 1917 (Address) 1937 Jonquil St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Dec. 29, 1917

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern Av

Spec.—8-24-14—M. & T.—2000 Bks.

D11322 HEALTH DEPARTMENT—CITY OF BALTIMORE D11322

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 E Pleasant St.; 4 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Buderer.

(Residence in Baltimore: No. 8 E. Pleasant St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word.) Widow

6-DATE OF BIRTH, August 20, 1830 (Month) (Day) (Year)

7-AGE, 87 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ludwig Kiefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Buderer.

(Address) 8 E Pleasant St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1917, to Dec 27 1917, that I saw her alive on Nov 30 1917, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

..... General Insufficiency Old age.

..... (Duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency & heart

..... (Duration) yrs. 1 mos. ds.

(Signed) E. Oliver Murray M. D.

Dec 28, 1917. (Address) 1221 W. Lafayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 29, 1917.

20-UNDERTAKER Mrs A Rohde & Son — ADDRESS 730 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D11323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11323

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Infirmary ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Augustus Tyler

(Residence in Baltimore: No. 1221 McCulloh St.

St.; 46 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 28, 1871
(Month) (Day) (Year)

7-AGE, 46 yrs. 5 mos. ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Straw hat worker
(b) General nature of industry, business, or establishment in which employed (or employer): ?

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George W. Tyler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Pine.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank D. Worthington M. D.

(Address) Union Protestant Infirmary

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1917, to Dec 28 1917, that I saw h[illegible] alive on Dec 28 th 1917, and that death occurred, on the date stated above, at 2.10 A m.

The CAUSE OF DEATH* was as follows:

Uremia — Acute Nephritis

Chronic Diffuse Nephritis

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. R. Micklethwaite M. D.

Dec. 28, 1917 (Address) Union Protestant Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3+ ds. In the State 46 yrs. 5 mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 1221 McCulloh St

19-PLACE OF BURIAL OR REMOVAL, St Michaels Md

DATE OF BURIAL, Dec. 29, 1917

20-UNDERTAKER W. J. Mickey & Son

ADDRESS Pimlico

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 28 1917 ROBERT B. KRAUTER REGISTRAR

3

Spec.—8-24-14—M. & T.—2000 Bks.

D11324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11324

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Oram Ave. ST.; 13 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert August William Sommerwerck

(Residence in Baltimore: No. 2317 Oram Ave. St.; 12 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, July (Month) 7th (Day), 1865 (Year)

7-AGE, 52 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Tetley Tea Co.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unk

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Sommerwerck Jr.

(Address) 12 S St. N.E. Washington D.C.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 191 7, to 12-27 191 7, that I saw h[illegible] alive on 12-27 191 7, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with General Metastasis

..... (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia Nephritis

..... (Duration) yrs. 1 mos. ds.

(Signed) A. P. Barnett M. D.

12-28, 191... (Address) 1631 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Dec 31..., 1917

20-UNDERTAKER W. J. Eichmeyer Sons — ADDRESS Penna Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41 D11325

REGISTERED No. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 716 N. Fremont Ave. St.; 16 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert D Boss

(Residence in Baltimore: No. 716 N. Fremont Ave St... yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7 AGE: 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Caterer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): New York City

PARENTS

10 NAME OF FATHER: Geo. L. Boss

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert N. Boss

(Address) 716 N. Fremont

15.

Filed ....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 27th (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1917, to Dec 27th 1917, that I saw him alive on Dec 25th, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(Duration) One yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Van Williams M. D.

Dec 27, 1917 (Address) 811 Cathedral Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 31, 1917

20 UNDERTAKER: Wm J Tiekert Son — ADDRESS: North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D11326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D11326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The St Paul ST.; 11 WARD) REGISTERED NO. C.....

2-FULL NAME Theodore Caldwell Conway

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. The St Paul St.; 3 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, November (Month) 2nd (Day) 1872 (Year) 1917

7-AGE, 45 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), New York.

PARENTS.

10-NAME OF FATHER, Edward A Conway

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Fanny Rogers

13-BIRTHPLACE OF MOTHER (State or Country), Massachusetts.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fanny Rogers Conway

(Address) 138 E 23rd St. New York

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 27th (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 21 191.., to Dec. 27 191.., that I saw h.. alive on Dec. 27 191.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..yrs. ..mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) Fanny Rogers Conway M. D.

....., 191.. (Address) 138 E 23rd St New York City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, 12-29.., 191..7

20-UNDERTAKER Henry W Jenkins Sons Co — ADDRESS Gilmor & McCulloh

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11327 19 D 1327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 1327

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 567 Orchard ST. 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Anna Williams

(Residence in Baltimore: No. 567 Orchard St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fmale	Colo	Widow

6-DATE OF BIRTH, ..., 1867
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Williams

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm Grace

(Address) 567 Grd St

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Exhaustion of the Nervous System

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Dec 28, 1917. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Nat Cemetery	Dec 28, 1917.

20-UNDERTAKER	ADDRESS
Samuel T Kemp	578 W Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D11328

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D11328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Mason

(Residence in Baltimore: No. 1804 Little Walsh St St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. March 13, 1917
(Month) (Day) (Year)

7-AGE. ....yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Mason

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A J Smith

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 25, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1917 to Dec 25 1917, that I saw him alive on Dec 25 1917, and that death occurred, on the date stated above, at 10 4 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Meningitis (pneumococcus)

(Duration) 0 yrs. 0 mos. 2 ds.

(Signed) Henry B. Conrad M. D.

Dec 26, 191.7 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. dz. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1804 Little Walsh St

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, DEC 28 1917, 191...

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

James S. Monroe 618 N. Bruce St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11329 ✓ D11329

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N. Bruce ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James S. Monroe.

(Residence in Baltimore: No. 618 N. Bruce St.; 9 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 4- (Month) (Day), 1882 (Year)

7-AGE, 35 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hod Carrier
(b) General nature of industry, business, or establishment in which employed (or employer) D35

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Jas Monroe

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B. Monroe

(Address) 618 N. Bruce St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 191 7, to Dec 27 191 7, that I saw h.. alive on Dec 191 7, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) — yrs. — mos. 11 ds.

(Signed) F. C. Link M. D.

Dec 27, 191 7 (Address) 1313 W. Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Md

DATE OF BURIAL. DEC 30 1917, 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11330

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N Lombard St ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miles Carroll Valentine

(Residence in Baltimore: No. 1018 N. Lombard St. St.; ....yrs., 3 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec 26, 1913. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. 3 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country) 1018 N Lombard St Balto Md

PARENTS.

10-NAME OF FATHER, James H Valentine

11-BIRTHPLACE OF FATHER (State or Country). Selton Pa.

12-MAIDEN NAME OF MOTHER Katie C Fleisher

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H Hitzke

(Address) 1531 N Lombard St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26 1917, to Dec 26 1917, that I saw h im alive on Dec 26 1917, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary (Duration) 17 hours

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) E. Heller Hennig M. D.

12-27-, 191.7 (Address) 1111 Holland St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	Dec 28, 1917.

20-UNDERTAKER	ADDRESS
H H Hitzke	1531 N Lombard St

Certificate issued by permission from Dr. Preston 12-27-17

D113318 c 17

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D1331 79 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1635 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Diggs

(Residence in Baltimore: No. 1635 Division St.; 13 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, June 11, 1881
(Month) (Day) (Year)

7-AGE. 36 yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 070
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Diggs

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Ransom

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sister

(Address) 1635 Division

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
Two Months
(Duration) yrs. mos.
CONTRIBUTORY (Secondary) Exhaustion from
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
Dec 28, 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mathen Co Va. DATE OF BURIAL, Dec 30, 1917.

20-UNDERTAKER Samuel A Hensley ADDRESS 578 W Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11332

CERTIFICATE OF DEATH.

120 D11332

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1651 W. Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Garwood

(Residence in Baltimore: No. 1651 W. Monroe St.; 64 yrs., 11 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, January 16, 1853
(Month) (Day) (Year)

7-AGE, 64 yrs. 11 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Bath Maryland

PARENTS.

10-NAME OF FATHER, Richard Garwood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah A. Pierce

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin Garwood

(Address) 1651 W. Monroe St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15 1915, to Dec. 27 1917, that I saw h.. alive on Dec. 27 1917, and that death occurred, on the date stated above, at 5:20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John T. Garwood M. D.

Dec 27, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Dec. 31., 1917.
20-UNDERTAKER Zickler & Zickler	ADDRESS 1739 E. Eager

Spec.—8-24-14—M. & T.—2000 Bks.

D11333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D11333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Pinkney Place St.; 17 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie M. Brown

(Residence in Baltimore: No. 427 Pinkney Place St.: 40 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, April (Month) 10 (Day) 1878 (Year)

7-AGE, 39 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

037

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER, Alexander Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Alice Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Personette

(Address) 427 Pinkney Place

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1917, to Dec 28 1917, that I saw h[illegible] alive on Dec 28 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(Duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 2 ds.

(Signed) J. M. Lampman M. D.

Dec 28 1917 (Address) 826 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Dec 31, 1917.

20-UNDERTAKER John Herwig & Co — ADDRESS 2008 Eden

DEC 28 1917 ROBERT B. KRAMER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D11331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D11331

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1619 N Monroe St.; W. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha A Gelber

(Residence in Baltimore: No. 1619 Monroe St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Wht	Married

6-DATE OF BIRTH, July 20, 1883
(Month) (Day) (Year)

7-AGE, 34 yrs. 5 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore,

PARENTS.

10-NAME OF FATHER, Henry Callendar

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Louise Meyer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard Gelber

(Address) 1619 N Monroe St

15-

Filed....., 191.....

DEC 28 1917 ROBERT R. KRAUTER Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Inhalation Illuminating Gas
1619 N Monroe St
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) H. W. Culley (Coroner.) M. D.

Dec. 27, 1917. (Address) Fidelity

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Dec 29 1917
20-UNDERTAKER J Henry & Co	ADDRESS 200 E Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

D11335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D11335

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 E. Lombard ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Kinsmore Thrift

(Residence in Baltimore: No. 2221 E. Lombard.

St.: Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	married

6-DATE OF BIRTH, March (Month) 1 (Day), 1885 (Year)

7-AGE, 32 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Roman M. Kinsmore

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Adelaide J. Klatte

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F. Thrift

(Address) 2221 E. Lombard St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 26 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1913, to Dec. 26, 1917, that I saw her alive on Dec. 26, 1917, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Albert Lowlan M. D.

Dec 27, 1917. (Address) 1704 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Dec 29, 1917.
20-UNDERTAKER H. E. Hughes	ADDRESS 17 S. Broadway

DEC 29 1917 ROBERT R. CRAUTEN

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11336

CERTIFICATE OF DEATH.

37 D11336

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mandue

(Residence in Baltimore: No. 607 Vincent St. St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.)
Male	Black	Widower

6-DATE OF BIRTH, ... Aug. (Month) 25 (Day), 1869 (Year).

7-AGE, 48 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): " " 045

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wesley Mandue

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hospital

(Address) .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21 (Day), 1917 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 21 1917, that I saw him alive on Dec 21 1917, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Left Lung

Grip

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A. Smith M. D.

Dec 21, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds., In the State 2 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? 607 Vincent St.

Former or usual residence 607 Vincent St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 28 1917 ROBERT B. KRAUTER Burial Permit Clerk

Commissioner Health.

13410

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11337 **CERTIFICATE OF DEATH.** 91 D11337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Sykes

(Residence in Baltimore: No. 311 Pine St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 18 (Day), 1917 (Year)

7-AGE, 0 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Rogers Sykes

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Gertrude Beans

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hosp

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1917, to Dec 23 1917, that I saw her alive on Dec 23 1917, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

about (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ....yrs. mos. 2 ds.

(Signed) Edward L. Dench M. D.

Dec 24, 191 7. (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 311 Pine St

Former or usual residence 311 Pine St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

DEC 28 1917 ROBERT P. KNAUTH Commissioner of Health.

15408

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11338

CERTIFICATE OF DEATH.

28

D11338

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 S Belnord Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Brokenski

(Residence in Baltimore: No. 601 S Belnord ave. St.: 15 yrs., mos., da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ~~1871~~ March 17, 1876 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 9 mos. 9 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Walenty Brokenski

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josefa Brokenska

(Address) 601 S. Belnord Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1917, to — 191—, that I saw h— alive on Dec. 26 1917, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) A. T. Ries M. D.

Dec 28, 1917. (Address) 24 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Com	Dec 29, 1917.

20-UNDERTAKER	ADDRESS
Stephen J. Kwiatkowski	219 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11339

CERTIFICATE OF DEATH.

79 D11339

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 N. Wolfe ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Johnson

(Residence in Baltimore: No. 1205 N. Wolfe St.; 55 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Eliza Wheeler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry T. Howard

(Address) 1644 E. Monument St

15-

Filed ....., 191.....

Registrar.

DEC 28 1917 ROBERT P. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1917, to Dec. 27, 1917, that I saw him alive on Dec. 26, 1917, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

..... (Duration) ..... yrs. ..... mos. 17 ds.

(Signed) Wm. C. Robinson M. D.

Dec 29, 1917. (Address) 1520 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Zion — DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER Geo. G. Cook — ADDRESS Northern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11310 D11310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Kimball

(Residence in Baltimore: No. 2509 W. Pratt St.; 35 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH, Oct. 21, 1869 (Month) (Day) (Year)

7-AGE, 48 yrs. 2 mos. 6 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Christian B. Hebble

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Anna Enos

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Kimball

(Address) 2509 W. Pratt St.

15-

Filed ....., 191.... Registrar.

DEC 28 1917 ROBERT B. KRAMER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18 - 1917, to Dec 27 1917, that I saw her alive on Dec 26 1917, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Rheumatoid arthritis

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. 1 ds.

(Signed) Louis M. Hirsh M. D.

Nov 7, 1917 (Address) 1 Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 29 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 2509 W. Pratt St

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery DATE OF BURIAL, Dec. 31, 1917

20-UNDERTAKER M. H. Filgner ADDRESS 1422 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1311 ✓ D1311

CERTIFICATE OF DEATH.

180

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 Stafford ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fetch

(Residence in Baltimore: No. 3036 Stafford Pl St.: Fifo yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Meyers

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Fetch

(Address) 3036 Stafford St

15-

Filed....., 191.....

Registrar.

DEC 28 1917 JOSEPH F. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 27 (Day) 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 191 , to Dec 27 191 , that I saw h alive on Dec 26 191 , and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

..... Chronic Intestinal .....
..... Nephritis .....
..... (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Dysentery

..... (Duration) yrs. 1 mos. ds.

(Signed) W A Lucas M. D.

12/28, 1917. (Address) Irvington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec 29 1917

20-UNDERTAKER Howard H. Bell ADDRESS 707 Frederick Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D11312

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 502 Brunswick St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W Staple

(Residence in Baltimore: No. 502 Brunswick St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word)
Male	white	Single

6-DATE OF BIRTH, April 12, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Frederick Staple

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Earnestine Hardt

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Staple

(Address) 502 Brunswick

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Suffocation under the bed clothes while sleeping Accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Renton M. D.
(Coroner.)

Dec 28 1917 (Address) 702 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	Dec 28th 1917.
20-UNDERTAKER	ADDRESS
Charles H. Ball.	3109 Forest Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

Malvin Smart

D11313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C D11313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Hillman St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malvin Smart

(Residence in Baltimore: No. 928 Hillman St.; — yrs., 4 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Negro

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ Married (*Write* the word.)

6-DATE OF BIRTH, ... (Month) ....., ... (Day) ....., ... (Year)

7-AGE, 28 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

9-BIRTHPLACE, (State or Country), State of Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father-in-law E A Davis

(Address) 928 Hillman St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1917, to Dec 28 1917, that I saw h[illegible]ive on Dec 28 1917, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D Heath M. D.

Dec 28 1917 (Address) 936 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Dec 29, 1917
20-UNDERTAKER Mrs R A Elliott	ADDRESS 506 East Pratt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Blks.

D11311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11311

CERTIFICATE OF DEATH.

X 138

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Averill Osborne Osburn

(Residence in Baltimore: No. University Hosp St.; yrs., mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1894 (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, C. A. Miller

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Sarah Briley

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Nelson Osburn

(Address) Annapolis, Md.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-10- 1917, to 12-28- 1917, that I saw h[illegible] alive on 12/28- 1917, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Diffuse Nephritis

(Duration) Indefinite

(Signed) R. Brandt Wilcox M. D.

Dec 28, 191... (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. mos. 18 ds. In the State ..... yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Martinsburg W Va.

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va

DATE OF BURIAL, Dec 29th, 191 7

20-UNDERTAKER Henry W. Jenkins & Sons

ADDRESS 20 Orchard St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11345

CERTIFICATE OF DEATH.

D11345

159 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2037 Wilkins ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burns

(Residence in Baltimore: No. 2037 Wilkins ave St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug 3, 1869
(Month) (Day) (Year)

7-AGE, 48 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 011

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Michael Burns

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Burns

(Address) 2037 Wilkins ave

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence [redacted] by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound blowing the White front of head off
Suicidal Instant
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Melancholy
(Duration) yrs. mos. ds.

(Signed) James M. Kehlan M. D.
(Coroner.)
Dec 28 191. (Address) 706 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER J. C. Block — ADDRESS 1023 N Bolton

D11316 HEALTH DEPARTMENT—CITY OF BALTIMORE D11316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 1752

CITY OF BALTIMORE (No. Mercy Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard J Taylor

(Residence in Baltimore: No. 919 Ensor St. St.; yrs. 4/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	Married

6-DATE OF BIRTH, Oct 22, 1878.
(Month) (Day) (Year)

7-AGE, 39 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Tender
(b) General nature of industry, business, or establishment in which employed (or employer): Tender

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Taylor

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Tinker

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Taylor

(Address) 919 E Monument St

15-

Filed....., 191.....

B. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Head
by street car accident
Epilepsy ? Traumatic
Brain (Duration) Coroner's Case yrs. mos. ds.

CONTRIBUTORY (Secondary)
..... (Duration) yrs. mos. ds.

(Signed) Wm. Taylor M. D.
(Coroner.)
Dec 29, 1917 (Address) 919 E Monument St

*State (the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Oregon ? Baltimore St

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
G. R. Odenheimer	Dec 29, 1917

20-UNDERTAKER	ADDRESS
D. Fenton & Cullen	130 E. Fort Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11347

CERTIFICATE OF DEATH.

REGISTERED No. C 105

1-PLACE OF DEATH Union Protestant Infirmary

CITY OF BALTIMORE: (No. 1514 Division ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr Charles F Bevan

(Residence in Baltimore: No. 807 Cathedral St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 14th (Day), 1850 (Year)

7-AGE, 67 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Surgeon
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles F Bevan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Sarah J Carback

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J M Hundley

(Address) Union Protestant Infirmary City

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1917, to Dec 27 1917, that I saw h/m alive on Dec 26 1917, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

I Acute Dilatation of Heart
following operation for gastro-
enterostomy (II Duodenal ulcer)
(Duration) I 16 yrs. mos. I 1hr. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) L R Hicklethwaite M. D.
, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 67 yrs. 6 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 807 Cathedral St

19-PLACE OF BURIAL, OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER Stewart & Bowen Co — ADDRESS 108 W. Mt Vernon

Spec.—8-24-14—M. & T.—2000 Bks.

D11318 D11318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Payson ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Menkel

(Residence in Baltimore: No. 706 N. Payson St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 4 (Day), 1846 (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 7 mos. 24 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Menkel

(Address) 706 N. Payson

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 1916, to Dec 28 1917, that I saw him alive on Dec 26 1917, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Uraemia in Cirrhosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) M Brennan Hood M. D.

Dec 29, 1917. (Address) 626 N. Paulson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER Josiah Sayer ADDRESS 800 W. North Ave

DEC 29 1917 ROBERT E. KRAUTZ Registrar of Vital Records Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11319

CERTIFICATE OF DEATH.

109 D11319

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice F Robinson

(Residence in Baltimore: No. Hampden Court Apt. St.; 34 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 23, 1883 (Month) (Day) (Year)

7-AGE, 34 yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thos. Robinson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Hutchins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr H T Robinson

(Address) Cumberland Md

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 27, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-26 1917, to 12-29 1917, that I saw h— alive on 12-29 1917, and that death occurred, on the date stated above, at 6 20 a.m.

The CAUSE OF DEATH* was as follows:

Gangrene of Extremities

0 (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Appendicitis

(Duration) yrs. mos. ds.

(Signed) John C Clark M. D.

12/29 191 7 (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. 1 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hampden Ct. Apts.

19-PLACE OF BURIAL OR REMOVAL, Street Md

DATE OF BURIAL, Dec 29, 191..

20-UNDERTAKER Jas B Cook

ADDRESS 103 N Ballast

DEC 29 1917 ROBERT B. KRAUTER

3

Spec.—8-24-14—M. & T.—2000 Bks.

D11350

HEALTH DEPARTMENT—CITY OF BALTIMORE

172 D11350

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Jos. Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Whiteside.

(Residence in Baltimore: No. 625 N. North ave. St.; 69 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. Feb (Month) 2 (Day), 1827 (Year)

7-AGE. 90 yrs. 10 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Whiteside

(Address) 625 N. North

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25, 1917, to Dec 28, 1917, that I saw h[illegible] alive on Dec 28, 1917, and that death occurred, on the date stated above, at 10·30a m.

The CAUSE OF DEATH* was as follows:

Fracture of Right Hip

(Duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchs. pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) J. Edward Jones M. D.

12/28/, 191.7 (Address) St. Jo. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 625 N. North ave.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 31, 191.7

20-UNDERTAKER J. S. Cook — ADDRESS 1023 W. Balto St

(over)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D11351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S Bdway ST.; W WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hornuf

(Residence in Baltimore: No. 819 S Bdway St.; 6 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH, ... Nov 25 ....., 1843
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... 74 yrs. 1 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 5.30
(b) General nature of industry, business, or establishment in which employed (or employer)..... Eng. Marine

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Edward Horney

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John H. Ruhl .....

(Address)..... 819 S Bdway .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec 29 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1917, to Dec. 29 1917,
that I saw h[illegible] alive on Dec. 28 1917,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy Cerebral .....
..... with Convulsions .....
.....
.....
..... (Duration)..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary).....
..... (Duration)..... yrs. ..... mos. ..... ds.

(Signed) John H. Rehberger M. D.

Dec 29, 191... (Address) 709 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	Dec 31, 191...
20-UNDERTAKER	**ADDRESS**
H. Sander's Sons	710 Dolphin

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D11352

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 N. Robinson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Schubert Jr

(Residence in Baltimore: No. 323 N. Robinson

Sta 14 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 5th, 1913
(Month) (Day) (Year)

7-AGE, 4 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, William Schubert

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md.

12-MAIDEN NAME OF MOTHER Margaret Jerscid

13-BIRTHPLACE OF MOTHER (State or Country), Balto City Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Schubert

(Address) 323 N. Robinson St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 28 1917, that I saw him alive on Dec 27 1917, and that death occurred, on the date stated above, at 4:55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Obstruction of Bowels

(Duration) yrs. mos. ds.

(Signed) C. J. C. Haller M. D.

12/28, 1917. (Address) 2900 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem — DATE OF BURIAL, Dec. 31, 1917

20-UNDERTAKER H. Sander Sons — ADDRESS 1710 Pleasant St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11353

CERTIFICATE OF DEATH.

28 ✓ D11353

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Faby.

(Residence in Baltimore: No. 407 S. Ann St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Unknown (Month) (Day), 1869 (Year)

7-AGE, 48 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinet-
(b) General nature of industry, business, or establishment in which employed (or employer): maker

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Frank Faby

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Sutaka

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosie Faby

(Address) 407 S. Ann St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1915, to 12-27 1917, that I saw h[illegible] alive on 12-27 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. 7 mos. 25 ds.

CONTRIBUTORY (Secondary) Nephritis & Pneumonia (Both)

(Duration) yrs. mos. ds.

(Signed) Thos. A. Shuebe M. D.

12-27, 1917 (Address) 1611 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER John J. Cowden & Son

ADDRESS 901 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11351

CERTIFICATE OF DEATH.

119 D11351

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Brent ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Thomas

(Residence in Baltimore: No. 2219 Brent St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... March ....., 1859
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Abron Holland

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Daniel Holland .....

(Address) 1631 Presbury .....

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec ..... 28 ....., 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1917; to Dec 28 1917, that I saw her alive on Dec 27 1917, and that death occurred on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

..... Acute Nephritis .....

.....

.....

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) E. Williams M. D.

Dec 28, 1917. (Address) 1928 Bryan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Helen

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER James Brown

ADDRESS 1631 Presbury

DEC 29 1917 ROBERT B. KRAUSE REGISTRAR BALTIMORE CITY

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D11355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11355

CERTIFICATE OF DEATH.

42

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Forrest ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Schrueffer

(Residence in Baltimore: No. 919 Forrest St.: Life yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Sept 14, 1862 (Month) (Day) (Year)

7-AGE: 55 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Schrueffer

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Agnes Wickles

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L. Schrueffer

(Address) 1401 Holbrook St.

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 29, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1917, to Dec 28 1917, that I saw h[illegible] alive on Dec 29 1917, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Cedema Carcinoma of Uterus

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Hemorrhage

Tapeworm (Duration) yrs. 3 mos. ds.

(Signed) [illegible] M. D.

Dec 29 1917. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 31, 1917

20-UNDERTAKER: H. C. Wadefield — ADDRESS: 17 Fremont Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D11356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11356

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1016 Valley ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Kelly

(Residence in Baltimore: No. 1016 Valley St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month), 1 (Day), ... (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas E. Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country) dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Chabot

(Address) 1016 Valley St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1917, to Dec 28 1917, that I saw h/m alive on Dec 27 1917, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

.....

.....

Lobular Pneumonia

Hr (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F. Douglass M. D.

Dec 28, 1917 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER H. C. Westfield

ADDRESS 1st Belmont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D11357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11357

CERTIFICATE OF DEATH.

156

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1037 Fremont St., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L Herbert

(Residence in Baltimore: No. 1037 Fremont St.) 64 yrs., \ mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOW(ER) OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec 6, 1853 (Month) (Day) (Year)

7-AGE. 64 yrs. mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Watchman
(b) General nature of industry, business, or establishment in which employed (or employer). Gas Co

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Adam Herbert

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Agnes Cuppett

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J Herbert

(Address)

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Dec 28 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER Henry Koch & Son

ADDRESS 1301 E Eager St

B

Spec.—8-24-14—M. & T.—2000 Blks.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D1135S

D1135S

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 W. Fayette St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. McMahon

(Residence in Baltimore: No. 1637 W. Fayette St.; 60 yrs., \ mos., \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Not Known, (Month) ....., 1 (Day) ..... (Year)

7-AGE, about 76 yrs. \ mos. \ ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Timothy Callahan

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Nora O'Connell

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Reilly

(Address) 533 N. Gay St.

15-

Filed....., 191.....

B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th 1917, to Dec 25th 1917, that I saw her alive on Dec 25th 1917, and that death occurred, on the date stated above, at 8-9 m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Chronic Kidney

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Heart Weakness

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. A. Montgomery M. D.

Dec 29, 1917, (Address) 1501 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Dec 31, 1917

20-UNDERTAKER: Henry Hoeck & Son

ADDRESS: 301 E. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11359 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D11359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1331 Hergenreider St.; 21 WARD) REGISTERED No. C 175

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antony Lapuiskty

(Residence in Baltimore: No. 1331 Hergenreider St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
male	white	Single

6-DATE OF BIRTH, Aug 4, 1908
(Month) (Day) (Year)

7-AGE. 9 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Lapuiskty

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Patronis Peach

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Lapuiskty

(Address) 1331 Hergenreider

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed Chest + abdomen by freight train running over him

(Duration) 3 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) 1 yrs. mos. ds.

(Signed) James M. Kenton M. D.
(Coroner.)

Dec 29 191 7. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER John Gelias — ADDRESS 425 S Paca St

Spec.—5-19-13—M. & T.—500 Bks.

D11360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11360

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Upton Pl. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Berwick

(Residence in Baltimore: No. 1311 Upton Pl. St.; 9m yrs, mos. ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Dec. 29, 1916
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Berwick

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Sawyer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Starrod

(Address) 1311 Upton Pl.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12th 1917, to Dec. 15th 1917, that I saw h[illegible] alive on Dec. 18th 1917, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Allan B. Baldwin M. D.

Dec. 29. 1917. (Address) 700 Log. av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Dec 29, 1917

20-UNDERTAKER D. L. Brown & Son

ADDRESS 108 Monta St

DEC 29 1917 ROBERT P. KRAUTZ Registrar of Vital Statistics

3

Spec.—8-24-14—M. & T.—2000 Bks.

D11361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D11361

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Central ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Sherwood

(Residence in Baltimore: No. 214 N. Central ave. St.; 10 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1879 (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Vincent Hasay

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Marilla Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Buckhanan

(Address) 214 N. Central ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1917, to Dec 27, 1917, that I saw her alive on Dec 27 1917, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Robert J. Green M. D.

Dec 28, 1917. (Address) 120½ Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Warrenton Va — DATE OF BURIAL, 12/28, 191.7

20-UNDERTAKER Daniel T. Kennedy — ADDRESS 578 W. Baltimore

B

Spec.—8-24-14—[illegible] T.—2000 Bks.

D11362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11362

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Greenwillow ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Dawson

(Residence in Baltimore: No. 537 Greenwillow St.; ..... yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... last none ....., 1898.
(Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Young

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ella Boston

13-BIRTHPLACE OF MOTHER (State or Country). West River

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella Carroll

(Address) 1548 Argyle Ave

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1917, to Dec 29 1917, that I saw h[illegible] alive on Dec 28 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum and Intestines

..... (Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 31, 191 7

20-UNDERTAKER Samuel C Stevenson

ADDRESS 5187 Biddle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11363 +113 D11363

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Adams

(Residence in Baltimore: No. Mercy Hospital St.; yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Apr. 21, 1886. (Month) (Day) (Year)

7-AGE, 31 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Farmer

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Robert Adams

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Margaret Littlepage

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record

(Address) Mercy Hospital

15-

Filed....., 191.... B Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11 1917, to Dec 28 1917, that I saw him alive on Dec 28 1917, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Do not know

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Edward D. Jones M. D.

Dec 28, 1917. (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ... mos. 17 ds.

Where was disease contracted, if not at place of death? Concorde W Va

Former or usual residence Concorde W. Va

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
Concorde W Va	
20-UNDERTAKER	ADDRESS
George Leahy	Salem Depot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11361

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 Pennsylvania St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Heinmiller

(Residence in Baltimore: No. 1328 Pennsylvania Ave. St.; 9 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 4 (Day), 1842 (Year)

7-AGE, 75 yrs. 5 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Jacob Heinmiller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katharine E. Zulauf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George R. Heinmiller

(Address) 1328 Pennsylvania Ave.

15-

Filed ..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December 28th, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1st 1917, to Dec 28 1917, that I saw her alive on Dec 18 1917, and that death occurred, on the date stated above, at 8 50 A m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart, with dropsy, one year
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism
(Duration) Two yrs. mos. ds.

(Signed) Louis W. Kuhl M. D.

Dec. 29 191... (Address) 414 N. Greene St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine County

DATE OF BURIAL, Jan 1, 1918.

20-UNDERTAKER Zurbler Zurbler

ADDRESS 1739 E Eager

Spec.—8-24-14—M. & T.—2000 Bks.

D11365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11365

84

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Walbrook ave. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Frazer

(Residence in Baltimore: No. 2022 Walbrook ave. St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED,~~ WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. 7th, (Month) 24 (Day) 1917. (Year)

7-AGE, ...yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Lawrence Frazer.

11-BIRTHPLACE OF FATHER (State or Country), Garrett County. Md.

12-MAIDEN NAME OF MOTHER M. B. Wetzler.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Frazer

(Address) 2022 Walbrook ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 28 1917, that I saw h.. alive on Dec 27 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Prematur Birth

(Duration) ...yrs. ...mos. ...ds.

(Signed) [illegible] M. D.

Dec 28, 191.. (Address) 2224 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery.	....., 191..
20-UNDERTAKER	**ADDRESS**
George J. Beuth.	1735 Harford ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11366

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11366

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 W Saratoga St.; 4 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hector A. Griffin

(Residence in Baltimore: No. 718 W Saratoga St.; 77 yrs., mos. 7 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Dec 10, 1840 (Month) (Day) (Year)

7-AGE, 77 yrs. mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mckinnon

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw E Reed

(Address) 1024 W Lexington St

15-

Filed ....., 191.... Registrar.

DEC 29 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1917, to Dec 27 1917, that I saw h alive on Dec 27 1917, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hem.
Cirrhosis
(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) yrs. mos. ds.

(Signed) H Norwood M. D.

Dec 29, 1917. (Address) 939 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Dec 29, 1917.

20-UNDERTAKER Samuel T Hemsley — ADDRESS 578 W Baltimore

D11367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11367

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1418 Battery Ave. St.: 24 WARD) 29

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dennis A.McLaughlin.

(Residence in Baltimore: No. 1418 Battery Ave.) St.: 52 yrs., mos. 14 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White.	Married

6-DATE OF BIRTH, December 14th. 1865. (Month) (Day) (Year) 1

7-AGE,	If LESS than 1 day,
52 yrs. -- mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Internal Revenue
(b) General nature of industry, business, or establishment in which employed (or employer): Gauger. 086

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles McLaughlin.

11-BIRTHPLACE OF FATHER (State or Country), Ireland. Md.

12-MAIDEN NAME OF MOTHER Bridget Sweeney.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McLaughlin.(wife)

(Address) 1418 Battery Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28th. 1917. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) yrs 2 mos.....ds.

(Signed) Geo. M. Lemmandk M. D. (Coroner.)

Dec. 29th. 191 7 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Dec. 31., 191 7.
20-UNDERTAKER	ADDRESS
John J Taber & Sons	318 Light St

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11365

151

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2022 Hanover St ST 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Teobe Hewett

(Residence in Baltimore: No. 2022 Hanover St. St.: yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH ..... (Month) ..... (Day) , 191.. (Year)

7 AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M J Lesser

(Address) 2022 Hanover St

15

Filed DEC 29 1917, 191.. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) , 191.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191.., to ....., 191.., that I saw h.. alive on ....., 191.., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenmount Md	Dec 30 1917

20 UNDERTAKER Geo D Gerber ADDRESS Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 11369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 11369

1-PLACE OF DEATH

CITY OF BALTIMORE (No. May Edmondson Av. Car Barn in St.: 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph B. Schwartz

(Residence in Baltimore: No. Gaithersburg Md St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Nov 20, 1856 (Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 014

9-BIRTHPLACE, (State or Country), Frederick Co. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph B. Schwartz Jr.

(Address) Gaithersburg Md.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Riley M. D. (Coroner.)

Dec 29, 1917. (Address) 1629 Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Rockville Md	Dec 31, 1917.
20-UNDERTAKER W. J. Sutton Sons	ADDRESS Gaithersburg Md

DEC 29 1917 DOROTHY R. KRAUTER SPECIAL DEPUTY REGISTRAR

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11370

CERTIFICATE OF DEATH.

17 D11370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 E. Chase ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Wellman Mitchell

(Residence in Baltimore: No. 9 E. Chase St ST.; 7 mos yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 4, 1869, (Month) (Day) 1 (Year)

7-AGE, 58 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hiram Woods

(Address) 842 Park Ave Balto.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, (Month) (Day) 1917. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1917, to Dec 28 1917, that I saw him alive on Dec 28 1917, and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Influenza
(Duration) 10 days

CONTRIBUTORY (Secondary) Acute Dilatation of Heart
(Duration) 24 hours

(Signed) H. Carroll Lockard M. D.

Dec 29, 1917. (Address) 4 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, 12-30-1917.

20-UNDERTAKER Henry W. Jenkins & Son Co — 20 Edward McCulloh Dr

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 30 1917 ROBERT R. KRAETZER

(Over)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11371

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1704 W. Mulberry St. 20 WARD)

Registered No. C 10 D11371

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Florence Ella St. Fairbanks

(Residence in Baltimore: No. 1704 W. Mulberry St.: 35+ yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH Feb 27, 1860 (Month) (Day) (Year)

7 AGE 57 yrs. 9 mos. 4 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Cookesville, Howard Co. Md

PARENTS

10 NAME OF FATHER Geo. Bird H. Stobbs

11 BIRTHPLACE OF FATHER (State or country) Cookesville, Howard Co Md

12 MAIDEN NAME OF MOTHER Catherine Ann Stobbs

13 BIRTHPLACE OF MOTHER (State or country) Cookesville Howard Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Stobbs

(Address) 1704 W. Mulberry

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 28, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1917, to Dec 28 1917, that I saw her alive on Dec 28 1917, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic Bronchitis (T.B. Negative)

(Duration) ..... yrs. 7 mos. ..... ds

Contributory (SECONDARY) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

DEC 29 1917 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Druid Ridge | DATE OF BURIAL Dec 30, 1917

20 UNDERTAKER John J. Feldis | ADDRESS 1200 W. Fayette St

DEC 30 1917 ROBERT D. CLAUDER [illegible]

D11372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11372

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. St. Joseph Hospital St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Fields.

(Residence in Baltimore: No. 1417 Preston St., St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 17, 1856
(Month) (Day) (Year)

7-AGE, 61 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John L Lipins

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Regina Melchior

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Fields

(Address) 1417 E. Preston

15-

Filed 30, 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Barbitol

When Dec 27

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

Dec 29, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon

DATE OF BURIAL, 12/31, 19..

20-UNDERTAKER William Cook

ADDRESS 507 N Wolfe

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11373

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1430 W. Mount St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Henry Neal

(Residence in Baltimore: No. 1430 W. Mount St.; ..yrs., 1 mos. ds.)

30 yrs in City

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, May (Month) 4 (Day) 1875 (Year)

7-AGE, 42 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, James Samuel Neal

11-BIRTHPLACE OF FATHER (State or Country), A A Co. Md

12-MAIDEN NAME OF MOTHER Georgiana Diggs

13-BIRTHPLACE OF MOTHER (State or Country), A A Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Annie Neal

(Address) 1340 Whitmore St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27 1917, to Dec 27 1917, that I saw h[illegible] alive on Dec 27 1917, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculosis

..... (Duration) ....yrs. 6 mos. ?.... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm H Wrigley M. D.

Dec 27, 1917. (Address) 1209 Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Dec 30, 1917.

20-UNDERTAKER Geo H Holland

ADDRESS 1631 Druid Hill

Spec.—8-24-14—M. & T.—2000 Bks.

D11371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11371

CERTIFICATE OF DEATH.

1 64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 W. Cary St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella May Dixon

(Residence in Baltimore: No. 1339 W. Cary St.; 26 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	Col	Single

6-DATE OF BIRTH, March 25, 1884
(Month) (Day) (Year)

7-AGE, 33 yrs. 9 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER, George Dixon

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia

12-MAIDEN NAME OF MOTHER Martha Myers

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Dixon

(Address) 1339 Cary St

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1917, to Dec 27 1917, that I saw h alive on Dec 27 1917, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cerebral Hemorrhage

..... (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

..... (Duration) yrs. mos. 10 ds.

(Signed) Wm H Wright M. D.

Dec 27, 191 7. (Address) 1209 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Dec 30, 191 7
20-UNDERTAKER	ADDRESS
Jno H Jackson	13 W Hill

(Over)

Spec.—8-24-14—M. & T.—2000 Bks.

Kasper Cofield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11375

CERTIFICATE OF DEATH.

8 D11375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Stirling ST.: 10 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kasper cofield

(Residence in Baltimore: No. 714 Stirling St. 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Oct 28 (Month) (Day), 1917 (Year)

7-AGE, ...yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jame Cofield

11-BIRTHPLACE OF FATHER (State or Country), Floradg

12-MAIDEN NAME OF MOTHER Carie Bordly

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father James Cofield

(Address) 714 Sterling St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 30 1917, that I saw him alive on Dec 30 1917, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Whooping cough

Spasms Exhaustion

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping cough

(Duration) ....yrs. ....mos. 5 ds.

(Signed) W. H. Hammond M. D.

Dec 30, 1917. (Address) 708 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Dec 31, 1917.
20-UNDERTAKER	ADDRESS
Mrs B A Elliott	506 East Pr

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D11376

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

D11376

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1721 Ashburton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael R Tyrrell

(Residence in Baltimore: No. 1721 ashburton St., 60 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Feb. (Month) 19, (Day) 1838 (Year)

7-AGE: 79 yrs. 10 mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Retired Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): 025

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: Geo. Tyrrell

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Annie A. Mallon

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Tyrrell

(Address) 1017 Lombard

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 28 (Day) 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-27, 1917, to, 12-28 1917, that I saw him alive on 12-28 1917, and that death occurred, on the date stated above, at 7.55 p m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(Duration) 2 yrs 8 mos ds.

Contributory (SECONDARY) Apoplexy Pressure

Pulmonary (Duration) 4 hrs mos ds.

(Signed), A.R. Cullen M. D.

12-29 1917 [Address] 2737 Wilmot Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL: Dec 30 1917

20-UNDERTAKER: J. Freeman ADDRESS 705 Hanover

DEC 29 1917 ROBERT E. KRAUSE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D1377

CERTIFICATE OF DEATH.

150 D1377

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 Raborg St.: 4 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Smith.

(Residence in Baltimore: No. 726 Raborg. St.:)

yrs, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	Colored	Sing'l.

6-DATE OF BIRTH, September 28, 1917.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 3 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE, (State or Country), Maryland. Balto

10-NAME OF FATHER, Governor Smith

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Dora Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Smith

(Address) 726 Raborg

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Albert L. Driscoll M. D.
(Coroner.)

Dec 29, 1917. (Address) 711 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Dec 31, 1917.

20-UNDERTAKER Felix B. Pye — ADDRESS 1037 E Mulberry.

DEC 30 1917 ROBERT B. KRAUTER

764

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11378

CERTIFICATE OF DEATH

61 ✓ D11378

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 751 Pierce St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Jones

(Residence in Baltimore: No. 751 Pierce St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Black	Widowed

6 DATE OF BIRTH December 25, 1866, 1
(Month) (Day) (Year)

7 AGE 51 yrs. — mos. 3 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: General Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9 BIRTHPLACE (State or country): York County Va.

PARENTS

10 NAME OF FATHER: Samuel Jones.

11 BIRTHPLACE OF FATHER (State or country): Gloster, Co. Va.

12 MAIDEN NAME OF MOTHER: Sarah Cook.

13 BIRTHPLACE OF MOTHER (State or country): Gloster, Co. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Thomas

(Address) 225 N Broad St

15.

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 (Month) 28 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1917, to Dec 28 1917, that I saw h- alive on Dec 24, 1917, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. mos. 2 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

(Signed) T. Blackwood M. D.

Dec 28, 1917 (Address) 2 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: Dec 31, 1917

20 UNDERTAKER: Felix B Pyc | ADDRESS: 102 E. Mulberry St

Spec.—8-24-14—M. & T.—2000 Bks.

Mary B Laczkowska

D11379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D11379

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 243 S Ann ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Blaczkowska

(Residence in Baltimore: No. 243 S. Ann St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem'l

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb 1 (Month) (Day) 1858 (Year)

7-AGE, 58 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland. Germ

PARENTS.

10-NAME OF FATHER, Joseph Blaczkowsky

11-BIRTHPLACE OF FATHER (State or Country), Poland Germany

12-MAIDEN NAME OF MOTHER Agnes Mankowski

13-BIRTHPLACE OF MOTHER (State or Country), Poland Germ

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Blackowska Wife

(Address) 243 S. Ann St.

15-

Filed ....., 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 28 (Month) (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1914, to Dec 27 1914, that I saw h[er] alive on Dec 27 1914, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis & Diffuse Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

(Signed) Wm A Mueller M. D.

12-29, 191... (Address) 416 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Dec 31, 1914

20-UNDERTAKER W. F. Wadowski ADDRESS 405 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11380 — 151 — D11380

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1509 Eastern ave St.: 3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edward Kaminsky

(Residence in Baltimore: No. 1509 Eastern ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Dec. (Month) 28 (Day), 1917 (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. | If LESS than 1 day 24 hrs. or 15 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): 1509 Eastern ave Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Kaminsky

11 BIRTHPLACE OF FATHER (State or country): U. S. A.

12 MAIDEN NAME OF MOTHER: Tilla Sroka

13 BIRTHPLACE OF MOTHER (State or country): U. S. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Kaminski.

(Address) 1509 Eastern Ave

15

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 29 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1917, to Dec. 29, 1917 that I saw h[illegible] alive on Dec. 29, 1917 and that death occurred, on the date stated above, at 2[illegible] m.

The CAUSE OF DEATH* was as follows:

Prematurity birth

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. Mc Devitt M. D.

Dec 30, 1917 (Address) 1721 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Rosary. | DATE OF BURIAL: Dec 31, 1917

20 UNDERTAKER: W. F. Sadowski | ADDRESS: 705 S. Ann

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

12615

D11381

HEALTH DEPARTMENT---CITY OF BALTIMORE

91 ✓ D11381

CERTIFICATE OF DEATH

1-PLACE OF DEATH Robert Garrett Hosp. REGISTERED No. C.....

CITY OF BALTIMORE: (No. ..... St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Stapf

(Residence in Baltimore: No. 105 N. Appleton St.; yrs. 5 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: July 15th (Month) (Day), 1917 (Year)

7-AGE: ..... yrs. 5 mos. 15 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Geo W. Stapf,

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Mary Madden

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Geo W Stapf

(Address) 105 N Appleton St

15-

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17, 1917, to, Dec 30 1917, that I saw him alive on Dec 29 1917, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Primary (Duration) — yrs — mos 14 ds.

Contributory (SECONDARY) ..... (Duration) ... yrs ... mos ... ds.

(Signed), John F Koch M. D.

Dec 30, 1917. [Address] 27 N Bond St

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos 13 ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Jan 1st, 1918

20-UNDERTAKER: John F Howard & Son ADDRESS: 701 Hollins St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11382 D11382

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Richardson

(Residence in Baltimore: No. Mercy Hospital St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, ...July.... (Month) ....1.... (Day), 1854 (Year)

7-AGE, 63 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas Richardson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Virginia Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. conf. Mercy Hosp.

(Address) Mount St.

15-

Filed ....; 191....

Registrar.

DEC 30 1917 ROBERT R. KRAUTER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1917, to Dec 30 1917, that I saw him alive on Dec 30 1917, and that death occurred, on the date stated above, at 12.04 m.

The CAUSE OF DEATH* was as follows:

I. Pertussis Pneu

Pneumonia

Don't Know (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) Edward A. Smith M. D.

Dec 30, 1917. (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 11 ds. In the State 5 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Sykesville Md

Former or usual residence Sykesville Md

19-PLACE OF BURIAL OR REMOVAL, Mudd Hill

DATE OF BURIAL, Dec 31, 1917.

UNDERTAKER E. J. Hale

ADDRESS 115 Ellen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D11383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D11383

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 East Center ST.: 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome J. Ellinger

(Residence in Baltimore: No. 20 East Center St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, (Month) Mar (Day) 1 (Year)

7-AGE, Years 53 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob Ellinger

11-BIRTHPLACE OF FATHER (State or Country) Bervia

12-MAIDEN NAME OF MOTHER Mary E. Baker

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Ellinger

(Address) 314 St Paul Street

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec (Day) 29, (Year) 1917.

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cal. Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. T. Riley M. D.
(Coroner.)
Dec 30, 191.7 (Address) 1639 Bond,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	12/31, 19 17.
20-UNDERTAKER Wallace Cook	ADDRESS 506 E North

Dr Riley 1639 Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11381 D11381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Huntingdon Ave. St.; 17 WARD)

REGISTERED NO. C 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Althoff

(Residence in Baltimore: No. 2929 Huntingdon Ave St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. 23, 1847
(Month) (Day) (Year)

7-AGE, 69 yrs. 11 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, David H. Althoff

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Isabella Seidenstricker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed ..... 191.....
Registrar.

DEC 31 1917 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 29, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23 191 , to Dec 29 191 , that I saw h alive on Dec 29 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. A. Benson M. D.

Dec 30, 1917. (Address) 112 W. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D11385

Sylvia Troyer.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102 D11385

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St.; 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia Troyer

(Residence in Baltimore: No. 1519 W. 36th St. St.; .....yrs. .....mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH. ..... (Month) Nov. (Day) 18 (Year) 1898.

7-AGE. 18 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Will Operator
(b) General nature of industry, business, or establishment in which employed (or employer) Md. Tel. & Tele. Co. Home Office

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles E. Troyer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Cora Stultz

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Troyer

(Address) 1519 W. 36th St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7- 1917, to Dec 29 1917, that I saw her alive on Dec 29 - 1917, and that death occurred, on the date stated above, at 9.34 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Peptic Ulcer

..... (Duration) 1 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia - secondary

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benj. M. Fox M. D.

Dec 29, 191 7. (Address) Md. General Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. W ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1519 W. 36th St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER Leonard Strauss	ADDRESS 1417 Eutaw Pl.

N. B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D11386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11386
REGISTERED NO. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Franklin Square Hospital ST.: 16 WARD) 119

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Balderston

(Residence in Baltimore: No. 629 N Pulaski St St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Nov (Month) 30 (Day), 1864 (Year)

7-AGE, 53 yrs. 1 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Journeyman

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Marcellus Balderston

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Margaret Hiebert

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Mandly

(Address) 629 N. Pulaski St

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Cerebral Hemorrhage
Alcoholic

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Durntion) ..... yrs. ..... mos. 2 ds.

(Signed) James M. Lawlor M. D.
(Coroner)

Dec. 30 1917 (Address) 1 W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Balto City

Former or usual residence 629 N Pulaski St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec. 31, 19 17

20-UNDERTAKER John O'Meiklejohn — ADDRESS 1101 W. Fayette

DEC 31 1917
ROBERT P. KRAUTER

Spec.—8-24-14—M. & S.—2000 Bks.

D11387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11387

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N Luzerne St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisia Jane Batterson

(Residence in Baltimore: No. 32 N Luzerne St.; 75 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
FEMALE	WHITE	MARRIED

6-DATE OF BIRTH, DEC-9- (Month), (Day), 1857 (Year)

7-AGE, 60 yrs. XX mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: HOUSEHOLD DUTIES (IN OWN HOME)
(b) General nature of industry, business, or establishment in which employed (or employer): 1

9-BIRTHPLACE, (State or Country), WELLS MILL- OCEAN Co NEW JERSEY

PARENTS.

10-NAME OF FATHER, EZERIAL COOPER GIBERSON

11-BIRTHPLACE OF FATHER (State or Country), MILLVILLE, OCEAN Co NEW JERSEY

12-MAIDEN NAME OF MOTHER LUCRETIA CURLIS

13-BIRTHPLACE OF MOTHER (State or Country), MILLVILLE, OCEAN Co NEW JERSEY

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucretia Gibson (MOTHER)

(Address) 32 N LUZERNE AVE, BALTO. MD.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month), (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th 191 7, to Dec 30 191 7, that I saw h[er] alive on Dec 30 191 7, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia & Asthma

(Duration) ... yrs. ... mos. 2 ds.

(Signed) C. K. Meyer Jr. M. D.

Dec 30th, 191 7. (Address) 2638 E Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, June 2, 191 8

20-UNDERTAKER W. J. Tickner — ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md Gen. Hospital

CITY OF BALTIMORE: (No. Lindenwood Manor ST.; 19 WARD)

REGISTERED NO. C 1114

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Emma Einwachter.

(Residence in Baltimore: No. 1605 W. Fayette St

St. Life yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, February 21, 1878 (Month) (Day) (Year)

7-AGE, 39 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph S. Townsend deceased

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia Pa

12-MAIDEN NAME OF MOTHER Anna M. E. Bush

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. May Townsend

(Address) 1605 W. Fayette St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27 1917, to Dec. 29 1917, that I saw h.er alive on Dec 29 1917, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ....yrs. ....mos. 72 ds.

CONTRIBUTORY (Secondary) Fall Hudson Stone,

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....., M. D.

12-29, 1917 (Address) Md Gen Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 38 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1605 W. Fayette St.

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. | DATE OF BURIAL, Dec. 31, 1917.

20-UNDERTAKER W. J. Tickner | ADDRESS 1605 W. Fayette St.

D11389 HEALTH DEPARTMENT—CITY OF BALTIMORE D11389

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 519 S Belnord Ave ST.: 1 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Holbrook

(Residence in Baltimore: No. 519 S. Belnord Ave St.; yrs. 49 mos. da.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1839 (Year)

7-AGE, 78 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Maggie Menzel

(Address) 519 S. Belnord Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed Henry Lynch (Coroner) M. D.

Dec 29 1917. (Address) 16 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, 1-st German — DATE OF BURIAL, DEC. 31., 1917

20-UNDERTAKER Peter Nicolaus — ADDRESS 2046 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D11390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D11390

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S Washington ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Uriah E. Jones.

(Residence in Baltimore: No. 209 S. Washington St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 4th (Month) (Day), 1917 (Year)

7-AGE, ...yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William A. Jones.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Caroline Sigmund

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Jones.

(Address) 209 S. Washington St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29th, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 16 1917, to Dec'r 29 1917, that I saw him alive on Dec'r 29 1917, and that death occurred, on the date stated above, at 5.15 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

Primary (Duration) ....yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Capillary atelectasis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) R. T. Hardy M. D.

Dec 30, 1917 (Address) 1902 Bank St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Dec. 21st, 1917.

20-UNDERTAKER Lilly & Zeiler — ADDRESS [illegible]

DEC 31 1917 ROBERT E. KRAUTZ

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D11391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D11391

REGISTERED NO. C.....

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Ehm

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, ... Dec (Month) 25 (Day), 1917 (Year).

7-AGE. ..... yrs. ..... mos. 0 ds. If LESS than 1 day, 10 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Peter Ehm

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Johanna Smith

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 26 (Day), 1917 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1917, to Dec 26 1917, that I saw her alive on Dec 26 1917, and that death occurred, on the date stated above, at 12:10 m.

The CAUSE OF DEATH* was as follows:

..... Atelectasis .....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

DEC 31 1917 ROBERT T. [illegible] Commissioner Health.

DEC 29 1917 JOHNS HOPKINS HOSPITAL

10443

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D11392

CERTIFICATE OF DEATH

D11392

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 806 Hanover St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Angelo Diblasi

(Residence in Baltimore: No. 806 Hanover St.; yrs. 8 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: April 11, 1916 (Month) (Day) (Year)

7 AGE: 1 yrs. 8 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Rosario Diblasi

11 BIRTHPLACE OF FATHER (State or country): Italy

12 MAIDEN NAME OF MOTHER: V. Florio

13 BIRTHPLACE OF MOTHER (State or country): Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V. Florio

(Address) 806 Hanover St

15 DEC 31 1917

Filed ....., 191 ROBERT E. CRAUTER Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 30 (Month) (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1917, to Dec 30 1917, that I saw h— alive on Dec 29, 1917, and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pertussis 8 weeks

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 3 1 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Jno L Blackstone M. D.

Dec 31, 1917 (Address) 1028 Mt Vernon Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Vincents — DATE OF BURIAL: DEC 31 1917, 191

20 UNDERTAKER: ARMSTRONG-DERRY CO. — ADDRESS: 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D11393

CERTIFICATE OF DEATH.

18 D11393

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Riggs Av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur F. Pearce

(Residence in Baltimore: No. 1721 Riggs Av St.; 59 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. July (Month) 14 (Day), 1858 (Year)

7-AGE. 59 yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Night watch.
(b) General nature of industry, business, or establishment in which employed (or employer). man.

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John A. Pearce

11-BIRTHPLACE OF FATHER (State or Country). Balto Co.

12-MAIDEN NAME OF MOTHER Ruth A. Mecaslin

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Pearce

(Address) 1721 Riggs Av

15-

Filed....., 191.....

Registrar.

DEC 31 1917 ROBERT E. GRAFFEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 29 1917, that I saw him alive on " 28 1917, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Uncertain (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Indigestion

..... (Duration) — yrs. — mos. 7 ds.

(Signed) Chas C. Conley M. D.

12-29-, 1917. (Address) 1101 W. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem

DATE OF BURIAL. Jan 1., 1918.

20-UNDERTAKER Jos Jonolevo & Son

ADDRESS 217 S. Paca

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11391

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

91 D11391

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 807 N. Arlington Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah H Eaton

(Residence in Baltimore: No. 807 N. Arlington Ave St.; 60 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) 28 (Day), 1840 (Year)

7-AGE, 77 yrs. 8 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher and Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Akron Ohio

PARENTS.

10-NAME OF FATHER, Friend Eaton

11-BIRTHPLACE OF FATHER (State or Country), Akron Ohio

12-MAIDEN NAME OF MOTHER Mary Jane

13-BIRTHPLACE OF MOTHER (State or Country) Akron Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Eaton

(Address) 807 N. Arlington Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 17 1917, to December 29 1917, that I saw h[illegible] alive on December 29 1917, and that death occurred, on the date stated above, at 1.50 m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ..... yrs. — mos. 7 ds.

(Signed) Hubert F Steelman M. D.

Dec. 30, 1917. (Address) 1227 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Dec. 31, 1917.

20-UNDERTAKER Geo J Smith

ADDRESS 1000 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Blks.

Wm C. Thaxton

D11395

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

64 D11395

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Madison ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Clay Thaxton

(Residence in Baltimore: No. 1508 Madison Ave St.; 2 yrs., \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, Oct. 5, 1847
(Month) (Day) (Year)

7-AGE, 70 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), N. C.

PARENTS.

10-NAME OF FATHER: Wm Joseph Thaxton

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER: Cornelia A. Jeffries

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Clay Thaxton

(Address) 1508 Madison Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Found him lying dead a few moments 191, to 191, that I saw him alive on Dec. 30 1917, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Was in usual health

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wilson T. King M. D.

Dec. 31, 1917 (Address) 142 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, ..., 191..

20-UNDERTAKER George Johnston — ADDRESS 1 Gil 3139

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11396

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D11396

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2728 St. Paul St.; ST.: 17 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Eliason, Jr.

(Residence in Baltimore: No. 2728 St. Paul, St.: 17 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word)
male	white	Single

6 DATE OF BIRTH: January 12, 1887 (Month) (Day) (Year)

7 AGE: 30 yrs. 11 mos. 18 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: V. P.
(b) General nature of industry, business, or establishment in which employed (or employer): Potomac Steamboat Co.

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William C. Eliason

11 BIRTHPLACE OF FATHER (State or country): Delaware U.S.A.

12 MAIDEN NAME OF MOTHER: Mary E. Naudain

13 BIRTHPLACE OF MOTHER (State or country): Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary N. Eliason

(Address) 2728 St Paul St.

15.

Filed ....., 191 .....

REGISTRAR

DEC 31 1917 ROBERT R. KRAUTER Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1917, to Dec 30 1917, that I saw h[illegible] alive on Dec. 29, 1917, and that death occurred, on the date stated above, at 5:40 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) ... yrs. ... mos. 5 ds

Contributory (SECONDARY) Pulmonary Tuberculosis

(Duration) 3 yrs. ... mos. ... ds.

(Signed) Thos. E. O'Malley M. D.

Dec 30, 1917 (Address) 2508 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Dec ... 31 ... 1917

20 UNDERTAKER: George L. Smith

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11397

CERTIFICATE OF DEATH.

50 D11397

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Hebrew Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regina Kaufman

(Residence in Baltimore: No. 2809 Roberts Ave St.; 20 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Oct 7th, 1852
(Month) (Day) (Year)

7-AGE, 65 yrs. 2 mos. 22 ds.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Zacharias Fehrmer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Kaufman

(Address) 2809 Roberts Ave

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30, 1917.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 30 1917, that I saw h alive on Dec 30 1917, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Chronic Interstitial Nephritis (Duration) Unknown

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 1 ds.

(Signed) B Jacobson M. D.

Dec 30, 1917. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bait Hebrew — DATE OF BURIAL, Dec 31st, 1917.

20-UNDERTAKER David Bondheim — ADDRESS 118 W Mt Royal

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11398

CERTIFICATE OF DEATH.

D11398

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 N.Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Kaufmann,

(Residence in Baltimore: No. 601 N.Calhoun St., St.; 50 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White,

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widower,

6-DATE OF BIRTH, Jany. 22nd., 1845.
(Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House furnishings;
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, Kaufmann Kaufmann,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J.Kaufmann,

(Address) 601 N.Calhoun

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30th, 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1917, to Dec 30 1917, that I saw h vm alive on Dec 29 1917, and that death occurred, on the date stated above, at 330a m.

The CAUSE OF DEATH* was as follows:

.....Hypostatic Pneumonia

..... (Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Pylorus

..... (Duration) ...yrs. 4 mos. ...ds.

(Signed) Howard Kahn M. D.

Dec 31, 1917 (Address) 1902 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oheb Shalom,	Jany. 1st., 191 8

20-UNDERTAKER	ADDRESS.
Nard & Sondheim	118 W.Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11399

CERTIFICATE OF DEATH.

91 D11399

1-PLACE OF DEATH St Vincents Inf Asylum

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Elbiney Martin

(Residence in Baltimore: No. 1401 Division St.; 0 yrs., 0 mos. 0 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wht.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 25, 17
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Grace Martin

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. P. Rousseau

(Address) 1219 Madison Ave.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1917, to Dec 27, 1917, that I saw h[illegible] alive on Dec. 27, 1917, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ...yrs. 1 mos. ...ds.

(Signed) Geo. M. Taylor M. D.

..., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER M Fahey & Son

ADDRESS 606 Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

D11400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D11400
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 E Lafayette Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bab Edward Summers

(Residence in Baltimore: No. 1834 E Lafayette Ave St.; Bab yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Dec 30 (Month) (Day), 1917 (Year)

7-AGE.	If LESS than 1 day,
½ hour	....hrs. or....min.?
....yrs....mos....ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Edward Summers

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lillie Barranger

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Summers

(Address) 1834 E Lafayette Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1917, to Dec 30 191., that I saw him alive on Dec 30 191., and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

(a) Hemorrhage following
(b) Cervical Pregnancy
Caused Death by fibroid tumor of uterus
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
Dec 30, 191.. (Address) 1657 Riverside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, Dec 31st, 1917

20-UNDERTAKER Martin Fales Jr & Son — ADDRESS 1 E Lafayette Ave

DEC 31 1917

Spec.—8-24-14—M. & T.—2000 Bks.

D11401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D11401

REGISTERED NO. C.....

1-PLACE OF DEATH 8 & 8 minutes Put. Engh

CITY OF BALTIMORE: (No. 1401 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Stoutt.

(Residence in Baltimore: No. 1401 Division St.; .....yrs., 2 mos. 20 ds.)

N. B.—THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, July (Month) 13 (Day), 1917 (Year)

7-AGE, ...yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... U-2-E.

9-BIRTHPLACE (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Jas. S. Stoutt.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary E. Wayne.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. P. Rousseau.

(Address) 1214 Madison Ave.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1917, to Dec 29, 1917, that I saw him alive on Dec 29, 1917, and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(Duration) .....yrs. .....mos. 8 ds.

CONTRIBUTORY (Secondary) None

(Duration) .....yrs. .....mos. .....ds.

(Signed) Edward M.C. Gotthardt M. D.

Dec 29, 1917 (Address) 1215 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. 2 mos. 30 ds. In the State .....yrs. 5 mos. 15 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Dec 31, 1917
20-UNDERTAKER	**ADDRESS**
M. Fahey & Sons	606 Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D11402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11402

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mordecai Jacobs

(Residence in Baltimore: No. 3424 E. Lombard St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, January 11, 1917. (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Mordecai Jacobs

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Dora Schuman

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) Johns Hopkins Hospital

15-

Filed....., 191.... Registrar.

DEC 31 1917 REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 30, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 191 to Dec 30 191 7, that I saw h alive on Dec 30 191 7, and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Diphtheria laryngeal

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B. Conrad M. D.

Dec 31, 191 7 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3424 E Lombard St

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Cem. DATE OF BURIAL, Dec 31, 1917.

20-UNDERTAKER Filby & Sons ADDRESS 1030 Wolfe St

5 P m.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11403

CERTIFICATE OF DEATH.

D11403

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 N. Duncan ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie C. Weber

(Residence in Baltimore: No. 1732 N. Duncan St.; 24 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1900 (Year)

7-AGE, 17 yrs. 14 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): for Md Biscuit Co

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John B. Weber

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Margaret Braun

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B. Weber

(Address) 1732 N. Duncan st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec 29 1917, that I saw h[er] alive on Dec 29 1917, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Unknown Cause

(Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Walsh M. D.

Dec 31 1917 (Address) 712 E St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetary — DATE OF BURIAL, Jan 1/18, 191...

20-UNDERTAKER Christian Miller — ADDRESS 2334 Jefferson st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D11401

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 235 Grindall St. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise V.Bell.

(Residence in Baltimore: No. 241 Grindall St. St.; 48 yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married

6-DATE OF BIRTH, November 18th. 1869., 1 (Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Leonidas Tyler.

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Theresa Markley.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W.Bell. (Husband.)

(Address) 241 Grindall St.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20th. 1917., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Aortic Aneurism.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto H.A.Reinhardt M. D. (Coroner)

Dec. 20th. 1917. (Address) 1017 S.Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Dec. 22, 1917

20-UNDERTAKER F. A. Stevens ADDRESS 783 S. Hanover

D11405

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D11405

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 2627 N Charles St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME St John Carroll Sanford

(Residence in Baltimore: No. 2627 N Charles St.: 4 yrs. 11 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Jan 23, 1913 (Month) (Day) (Year)

7-AGE: 4 yrs. 11 mos. 8 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto.

PARENTS

10-NAME OF FATHER: John G Sanford

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Emmie Carroll

13-BIRTHPLACE OF MOTHER (State or country): Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emmie Sanford

(Address) 2627 N Charles St.

15

Filed DEC 31 1917, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 30, 1917 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1917, to Dec 30 1917,
that I saw h-m alive on Dec 30, 1917,
and that death occurred, on the date stated above, at 6 9 m.
The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Epilepsy

(Duration) 2 yrs. 6 mos. ..... ds.

(Signed) H E Bifelstar M. D.

Dec 30, 1917 (Address) 008 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Jan 1, 1918

20-UNDERTAKER: E A Windsfeld Jr — ADDRESS: Greenmount Ave.

11 a m.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D11406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120D11406

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 127 N Augusta St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Jim Patterson

(Residence in Baltimore: No. 127 N Augusta St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	colored	Widow

6-DATE OF BIRTH. Unknown, ... (Month) ..... (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
40 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Rock Funeral Home

(Address) 241 E. Fayette

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis 1

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Dec 31, 1917 (Address) 241 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Jan 2, 1918
20-UNDERTAKER	ADDRESS
Rock Funeral Home	241 E. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11407

CERTIFICATE OF DEATH.

38 D11407

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Margaret Darmer

(Residence in Baltimore: No. 1327 Cookesie St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 29 (Day), 1899 (Year)

7-AGE, 18 yrs. 6 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, Joseph Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Mary Mc Clure

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Baumer

(Address) 1327 Cookesie St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 31 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10th 1917, to Dec 31, 1917, that I saw h- alive on Dec 30th 1917, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Influenza

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion due to the above

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry G. Michel M. D.

Dec 31, 1917. (Address) St Agnes Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 20 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Jan 3, 1918

20-UNDERTAKER Wm. Cook

ADDRESS 502 E. Hoffman

DEC 31 1917

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D11408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D11408

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beulah B. Coxson

(Residence in Baltimore: No. 821 Bradly St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Oct 17 (Month) (Day), 1897 (Year)

7-AGE, 20 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Several house work Private family

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER, Frank Coxson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Olivia Coxson

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Coxson

(Address) 821 Bradley St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about Dec 18 1917, to Dec 27 1917, that I saw h[er] alive on December 27 1917, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pyelitis Disease (Duration and Nephritis)

about 2 weeks (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Abscess Cerebellum,

2 days (Duration) ....yrs. ....mos. ....ds.

(Signed) John L. Manger M. D.

....., 191... (Address) 1008 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER Charles B. Jones

ADDRESS 2352 W Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D11409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11409

108

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josphs Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Harris

(Residence in Baltimore: No. 16 S Spring St St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Unknown, 18?? (Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Geo. Harris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Chase

(Address) 16 S. Dallon St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1917, to Dec 28 1917, that I saw h m alive on Dec 27 1917, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. mos. ? ds.

(Signed) H Merkel M. D.

Dec 28, 1917 (Address) St Josphs Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Dec 31 1917

20-UNDERTAKER Harry A Vodery

ADDRESS 1725 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-28-14—M. & T.—2000 Bks.

D11410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D11410

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Keyser ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William B. Bannister

(Residence in Baltimore: No. 1716 Keyser St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1876 (Year)

7-AGE, 41 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Worked in Foundry

9-BIRTHPLACE, (State or Country), Hagerstown, Md.

PARENTS.

10-NAME OF FATHER, Cornelius Bannister

11-BIRTHPLACE OF FATHER (State or Country), Hagerstown

12-MAIDEN NAME OF MOTHER Sarah Collins

13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecelia Bannister, wife

(Address) 1716 Keyser St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 21 1917, to December 29 1917, that I saw him alive on dec. 29 1917, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

.....a.....

.....Pneumonia.....

.....

..... (Duration).....yrs.....mos....9...ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) W. C. Sandrock M. D.

Dec. 29, 1917. (Address) 1242 N. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Return Cem

DATE OF BURIAL. Dec 31 1917

20-UNDERTAKER Samuel T. Hensley

ADDRESS 573 W. Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11411

CERTIFICATE OF DEATH.

30 D11411

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland James

(Residence in Baltimore: No. 40 E. Church St St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, July (Month) 2 (Day), 1891 (Year)

7-AGE, 26 yrs. 5 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter Rose
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), D. C.

PARENTS.

10-NAME OF FATHER, Edw. James

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Agnes Douglas

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record Mercy Hosp

(Address) Church St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day), 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1917, to Dec. 28 1917, that I saw him alive on Dec. 28 1917, and that death occurred, on the date stated above, at 9.07 A m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

Duration 2 days

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 28 1917 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death? 40 E. Church St

Former or usual residence 40 E. Church St.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Jan. 1st, 1918.

20-UNDERTAKER Lee Brown & Son ADDRESS 108 N. Montgomery

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MERCY HOSPITAL
CONDUCTED BY THE SISTERS OF MERCY
CALVERT & SARATOGA STS
BALTIMORE, MD

2/1/1916.
1/31/1916

Reg. of Vital Statistics
Health Dept, City

Dear Sir: - The stub of the death certificate in this case shows the name of Conrad James instead of Conrad James. - The correct name is "Conrad".

Very truly yours
E. P. Smith, M.D.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D11412

REGISTERED NO. C 108 D11412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 W West St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Brown

(Residence in Baltimore: No. 512 W. West St.; 29 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1888 (Year)

7-AGE, 29 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Cook—Pr

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Brown

(Address) 512 W West St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1917, to Dec 29 1917, that I saw her alive on Dec 29 1917, and that death occurred, on the date stated above, at 9.5 a. m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(Duration) yrs. mos. ds.

(Signed) J. Lee Bowley M. D.

Dec 30, 1917. (Address) 136 W. West St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 31, 191...

20-UNDERTAKER J. K. Brown & Son ADDRESS 1157 Montgo...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D11413

CERTIFICATE OF DEATH.

120 D11413

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Myrtle Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Walson

(Residence in Baltimore: No. 1427 Myrtle ave St.; 4 yrs., mos. ds.)

In city - 40 yrs.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 10, 1865 (Month) (Day) (Year)

7-AGE, 52 yrs. 8 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lancaster Co. Va

PARENTS.

10-NAME OF FATHER, Joseph Laws.

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Va

12-MAIDEN NAME OF MOTHER Daffon Carter

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Watson

(Address) 1427 Myrtle ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1917 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1917, to Dec 28 1917, that I saw her alive on Dec 27 1917, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Chronic (Duration) 1 yrs. 2 mos. ds.

(Signed) Wm. H. Wright M. D.

Dec 29, 191 7 (Address) 1209 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Dec 31, 1917

20-UNDERTAKER Jas A Kenny ADDRESS 1303 Preston

DEC 31 1917 REGISTRAR'S OFFICE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARKING RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11411

CERTIFICATE OF DEATH.

D11411

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Valley ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Koenig

(Residence in Baltimore: No. 929 Valley St.; 22 yrs., 2 mos. 4 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAKING REQUIRED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October (Month) 25 (Day) 1895 (Year)

7-AGE, 22 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George Jos. Koenig

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Elizabeth Hille

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Koenig

(Address) 929 Valley St

15-

Filed....., 191.....

Registrar.

DEC 31 1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 29 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-12 1917, to 12-29 1917, that I saw h[er] alive on 12-29 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 1

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. Bernard Wh... M. D.

12-29, 191.. (Address) 9[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery Govans DATE OF BURIAL, Jan. 2, 1918

20-UNDERTAKER Henry Hoeck Sons ADDRESS 1501 E Eager St

Spec.—7-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11415

CERTIFICATE OF DEATH.

4V D11415
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 E Federal ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adeline Staley

(Residence in Baltimore: No. 407 E Federal St.; ~~Not Known~~ yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, October 10, 1835
(Month) (Day) (Year)

7-AGE, 82 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home 037

9-BIRTHPLACE, (State or Country), Hagerstown Md

PARENTS.

10-NAME OF FATHER, Christian Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Louisa Sowman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edward Conroy

(Address) 1502 N Carey

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1915, to Dec 30 1917, that I saw her alive on Dec 30 1917, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Edema (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (Duration) ....yrs. ....mos. ....ds.

(Signed) A Woodward M. D.

Dec 31, 1917 (Address) 1515 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Jan 3, 1918.

20-UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

MARGIN HERE RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11416

CERTIFICATE OF DEATH.

20 D11416

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Holbrook ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie M. Hamill

(Residence in Baltimore: No. 1213 Holbrook St.; 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Not Known ....., 1..... (Month) (Day) (Year)

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie M. Hamill

(Address) 1213 Holbrook St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29th, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended, deceased from December 26 1917, to December 29 1917, that I saw h[illegible] alive on December 29th 1917, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

and Exhaustion from Senile

Heart Failure (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lawrence Steadman M.D. M. D.

Dec 30, 191 7. (Address) 130 Eldorado Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. Jan. 2, 1918.

20-UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

7+ 915-12.30 cc

D11417 HEALTH DEPARTMENT—CITY OF BALTIMORE 16 D11417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 16 N Bykerd St. Ward) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Andrico

(Residence in Baltimore: No. 1630 Monroe ave St.; yrs. 4yrs mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, June (Month) X (Day) 1 (Year)

7-AGE, 5 yrs. 6 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Andrico

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Peluso

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Andrico

(Address) 1630 Monroe ave

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns accidents & acute nephritis & result causes fire

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed)..... M. D. (Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore County DATE OF BURIAL, Jan 1, 1918

20-UNDERTAKER Robert J Jones ADDRESS 1429 Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D11418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D11418

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S. Green ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Carr

(Residence in Baltimore: No. 720 S. Green St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	

6-DATE OF BIRTH, unknown ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, ... 53 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Any Kind

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... William Dance

(Address) 720 S. Green St

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec ..... (Month) 29 ..... (Day), 1917 ... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1917, to Dec 29 1917, that I saw him alive on Dec 28 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

..... Chronic Nephritis .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. 11 ..... ds.

(Signed) ..... M. D.

Dec 29, 1917. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Dec 31, 1917.
20-UNDERTAKER Wood Rogers	ADDRESS 16 W Mulberry St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

3

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

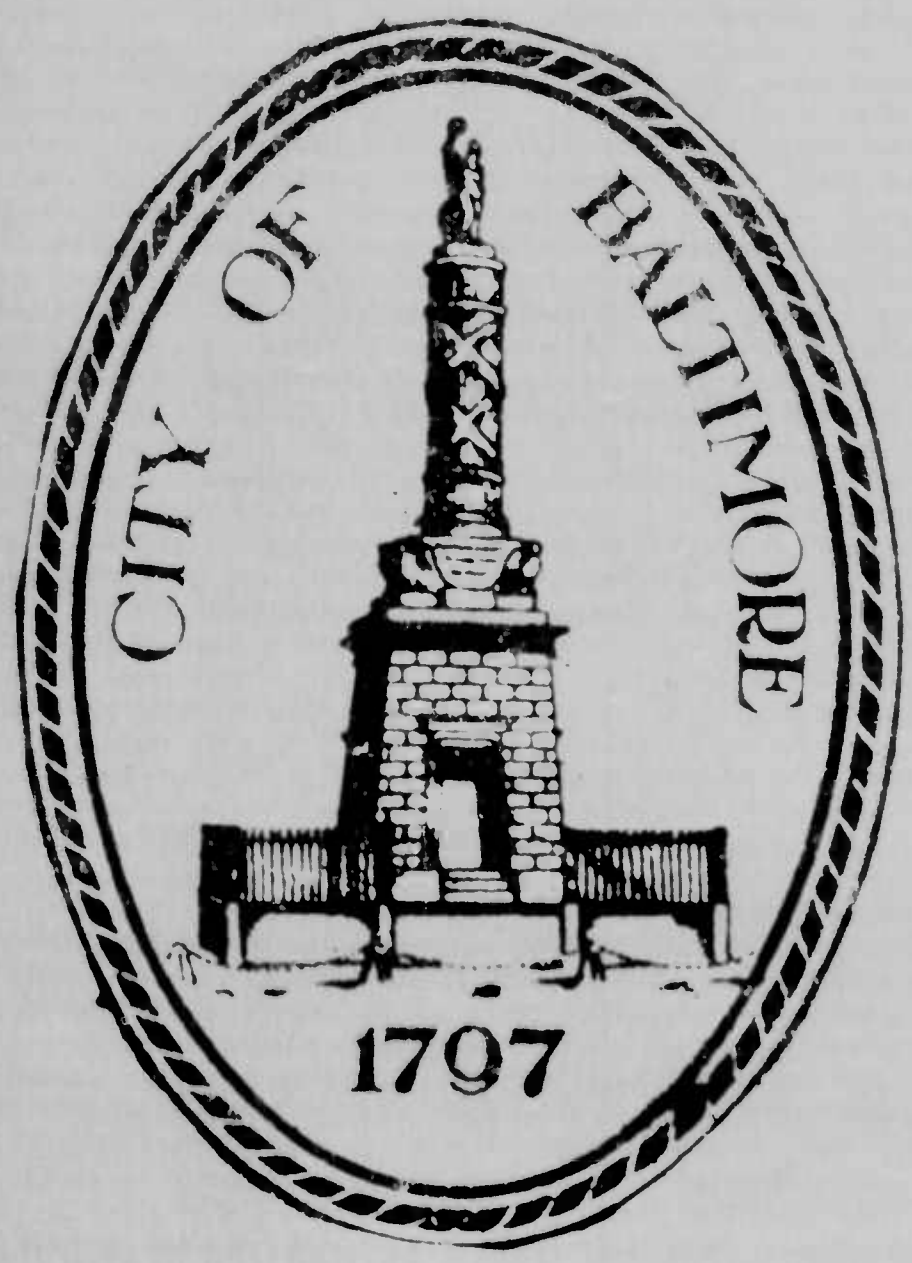
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 5rd DAY August
OF 1964 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #D 8201 Reg SEPT 6, 1917 AND
ENDING WITH #D-11418 -Reg Dec 31, 1917 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEIGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: L. Pryor



END OF REEL